CERTIFICATE OF NEED APPLICATION

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Tenet Healthcare Corporation and
Yale-New Haven Health Services Corporation

OHCA Docket Number: 14-31926-486 and
Attorney General Docket Number: 14-486-01

October 24, 2014

WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Melinda A. Agsten
203.498.4326
magsten@wiggin.com

Rebecca A. Matthews
203.498.4502
rmatthews@wiggin.com

October 24, 2014

VIA HAND-DELIVERY

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

The Honorable Jewel Mullen
Commissioner
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation
OHCA Docket Number: 14-31926-486 and Attorney General Docket Number: 14-486-01

Dear Attorney General Jepsen and Commissioner Mullen:

Eastern Connecticut Health Network, Inc. ("***ECHN***"), Tenet Healthcare Corporation ("***Tenet***") and Yale-New Haven Health Services Corporation ("***YNHHS***") (collectively, the "***Applicants***") hereby submit a Certificate of Need application (the "***Application***") for the proposed purchase of the assets of ECHN by a to-be formed joint venture between Tenet and YNHHS. At your request, two (2) hard copies and two (2) electronic copies have been provided to the Office of the Attorney General and seven (7) hard copies and three (3) complete electronic copies have been provided to the Office of Health Care Access. Please note that Exhibit 20 will be bulk filed as instructed by the Attorney General's office. Exhibit 35 has been provided only in electronic form as instructed by Application Question 49.

WIGGIN AND DANA

Counsellors at Law

The Applicants look forward to working with you and your staff through the approval process. If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By_____
Rebecca A. Matthews
Its Partner

By_____
Melinda A. Agsten
Its Partner

cc: Kevin T. Hansted, Hearing Officer, Office of Health Care Access
Gary W. Hawes, Assistant Attorney General
Dennis P. McConville, Senior Vice President for Planning, Marketing, and Communications, ECHN
Joyce Tichy, Esq., General Counsel, ECHN
Gayle Capozzalo, Executive Vice President, Strategy & System Development, YNHHSC
William J. Aseltyne, Senior Vice President & General Counsel, YNHHSC
Trip Pilgrim, Senior Vice President of Development, Tenet
Jeffrey Peterson, Senior Counsel, Tenet
Collin P. Baron, Esq., Pullman & Comley, LLC

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Application Checklist

Instructions:

1. **Please check each box below, as appropriate; and**
2. **The completed checklist *must* be submitted as the first page of the CON application.**

☒ **Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.**

For OHCA Use Only:

Docket No.: _____ Check No.: _____
OHCA Verified by:_____ Date: _____

☒ **Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)***

☒ **Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.**

☒ **Attached are completed Financial Attachments.**

☒ **Submission includes two (2) hard copies and two (2) electronic copies have been provided to the Office of the Attorney General and seven (7) hard copies and three (3) complete electronic copies have been provided to the Office of Health Care Access.**

Note: A CON application may be filed with OHCA electronically through email, if the total number of pages submitted is 50 pages or less. In this case, the CON Application must be emailed to ohca@ct.gov.

Important: For CON applications(less than 50 pages) filed electronically through email, the signed affidavit and the check in the amount of $500 must be delivered to OHCA in hardcopy.

☒ **The following have been submitted on a CD**

1. **A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.**
2. **An electronic copy of the documents in MS Word and MS Excel as appropriate.**

HOLD DOCUMENT UP TO THE LIGHT TO VIEW TRUE WATERMARK

OFFICIAL CHECK

HOLD DOCUMENT UP TO THE LIGHT TO VIEW TRUE WATERMARK

TD Bank

40579123=4

52-0133
112

RE: THE MANCHESTER MEMORIAL HOSPIT

DATE: 10/21/2014

PAY TO THE ORDER OF **TREASURER STATE OF CONNECTICUT**

$500.00

Five Hundred AND 00/100

HUB HERE COLOR FADES WITH HEAT

DRAWER: TD BANK, N.A.

AUTHORIZED SIGNATURE

[redacted] [redacted]04[redacted]

AFFIDAVIT

Applicant: Eastern Connecticut Health Network, Inc.

Project Title: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation

I, Peter Karl, (Individual's Name) President and Chief Executive Officer (Position Title – CEO or CFO)

of Eastern Connecticut Health Network, Inc. (Hospital or Facility Name) being duly sworn, depose and state that

Eastern Connecticut Health Network, Inc.'s (Hospital or Facility Name) information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Peter Karl
Signature

10-20-14
Date

Subscribed and sworn to before me on 20th, October, 2014

Chantal Perez
Notary Public/Commissioner of Superior Court

My commission expires: August 31, 2019

AFFIDAVIT

Applicant: Tenet Healthcare Corporation

Project Title: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation

I, Harold Pilgrim, (Individual's Name) Senior Vice President of Development (Position Title – CEO or CFO)

of Tenet Healthcare Corporation (Hospital or Facility Name) being duly sworn, depose and state that

Tenet Healthcare Corporation's (Hospital or Facility Name) information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 10/20/14 Date

Subscribed and sworn to before me on October 20, 2014

Kathleen M. Kennedy

Notary Public/Commissioner of Superior Court

KATHLEEN M. KENNEDY
Notary Public, State of Texas
My Commission Expires
September 30, 2015

My commission expires: 9/30/2015

AFFIDAVIT

Applicant: Yale-New Haven Health Services Corporation

Project Title: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation

I, Gayle L. Capozzalo, (Individual's Name) Executive Vice President & Chief Strategy Officer (Position Title – CEO or CFO)

of Yale-New Haven Health Services Corporation (Hospital or Facility Name) being duly sworn, depose and state that

Yale-New Haven Health Services Corporation's (Hospital or Facility Name) information submitted in this Certificate of Need Application is accurate and correct to the best of my knowledge.

Signature 10/22/14 Date

Subscribed and sworn to before me on 10/22/14

Notary Public/Commissioner of Superior Court

My commission expires: Irene Noel NOTARY PUBLIC State of Connecticut My Commission Expires 8/31/2018

Connecticut

LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes ("C.G.S"), as expected to be amended by Public Act 14-168, a nonprofit hospital seeking to transfer a material amount of its assets or operations or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty days after receipt of the letter.

Applicants
Eastern Connecticut Health Network, Inc.
Tenet Healthcare Corporation
Yale-New Haven Health Services Corporation

Town
Manchester, Connecticut

Proposal
Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to VHS Eastern Connecticut Health System, LLC, a Joint Venture to be formed between Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation

Date
Monday, June 23, 2014

Time
6:00 p.m.

Place
H. Louise Ruddell Auditorium
Manchester Memorial Hospital
71 Haynes Street, Manchester, Connecticut 06040

PLEASE NOTE:
A second public hearing will be held on Tuesday, June 24, 2014 beginning at 6:00 p.m. at the Vernon Senior Center located at 26 Park Place in Vernon, Connecticut 06066. Formal notice for this hearing has been published simultaneously in the Journal Inquirer.

PROPOSAL DESCRIPTION
Eastern Connecticut Health Network, Inc., including its affiliates (collectively, "ECHN") is seeking approval from the Office of Health Care Access ("OHCA") and the Office of the Attorney General, for the proposed transfer of certain of the assets of ECHN, including certain assets of ECHN's two hospitals, Manchester Memorial Hospital and Rockville General Hospital, and ECHN's ownership interests in affiliated entities, to VHS Eastern Connecticut Health System, LLC ("VHS"), a to-be-formed, for-profit entity and joint venture between Tenet Healthcare Corporation ("Tenet") and Yale-New Haven Health Services Corporation ("YNHHSC"). Tenet will own 80% of the membership interests of VHS and YNHHSC will own 20%. The estimated total project cost is $105,000,000, which is subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer.

The transfer will include the operating and other assets of ECHN (other than restricted charitable funds), including the properties, assets and businesses of, or ownership interests of ECHN and its affiliates in the following entities:
- Manchester Memorial Hospital, a licensed general hospital
- Rockville General Hospital, a licensed general hospital
- ECHN Eldercare Services, Inc. (d/b/a Woodlake at Tolland Rehabilitation & Nursing Center), a licensed chronic and convalescent nursing home
- Visiting Nurse and Health Services of Connecticut, Inc., a licensed home health care agency, and its direct subsidiary, A Caring Hand, LLC, a licensed homemaker-companion agency
- Clinically Integrated Network of Eastern Connecticut, LLC
- Connecticut Healthcare Insurance Company, Inc.
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC
- ECHN Enterprises, Inc.
- Haynes Street Property Management, LLC

The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:
- Aetna Ambulance Service, Inc., a licensed EMS organization
- Metro Wheelchair Service, Inc., a licensed EMS organization
- Ambulance Service of Manchester, LLC, a licensed EMS organization
- Evergreen Endoscopy Center, LLC, a licensed ambulatory surgical center
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Finally, the parties will work to restructure ECHN's medical foundation, Eastern Connecticut Medical Professionals Foundation, Inc. (the "ECHN Medical Foundation"). Consistent with Connecticut law, this restructuring will take the form of either (i) a member substitution, pursuant to which Tenet or an affiliate of Tenet will become the sole member of ECHN Medical Foundation; or (ii) a transfer of the assets and liabilities of ECHN Medical Foundation to a new medical foundation, the sole member of which will be Tenet or an affiliate of Tenet.

There are a number of features of the proposed transaction that will benefit the current employees and communities served by ECHN. Although not an exhaustive list, these features will include:
- Operation of ECHN's assets by VHS, a unique partnership between an established for-profit national hospital company and one of the nation's leading academic medical centers.
- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment , maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
- A commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.
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- Maintenance of ownership interest in ECHN's continuum of care network.
- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
- Affiliation with the Yale New Haven Health System, which will provide clinical expertise and aid in comprehensive service line development.
- A commitment to invest $75 million, beyond the estimated project cost, in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff.

No service changes are currently anticipated in connection with the proposed transaction. VHS will continue to provide care to the residents in the service area towns that have historically been served by ECHN including, Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, and Union.

ADDITIONAL INFORMATION
A copy of the certificate of need determination letter submitted to the Attorney General and OHCA as well as additional information on the scheduled public hearings can be found on the ECHN website at the following location: www.echn.org/caringnever-changes

Connecticut

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Pursuant to Section 19a-486 of the Connecticut General Statutes ("C.G.S"), as expected to be amended by Public Act 14-168, a nonprofit hospital seeking to transfer a material amount of its assets or operations or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty days after receipt of the letter.

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ADDITIONAL INFORMATION
A copy of the certificate of need determination letter submitted to the Attorney General and OHCA as well as additional information on the scheduled public hearings can be found on the ECHN website at the following location: www.echn.org/caringneverchanges

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Applicants
Eastern Connecticut Health Network, Inc.
Tenet Healthcare Corporation
Yale-New Haven Health Services Corporation

Town
Vernon, Connecticut

Proposal
Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to VHS Eastern Connecticut Health System, LLC, a Joint Venture to be formed between Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation

Date
Tuesday, June 24, 2014

Time
6:00 p.m.

Place
Vernon Senior Center
26 Park Place, Vernon, Connecticut 06066

PLEASE NOTE:
A second public hearing will be held on **Monday, June 23, 2014** beginning at **6:00 p.m.** at the Manchester Memorial Hospital H. Louise Ruddell Auditorium located at **71 Haynes Street, Manchester, Connecticut 06040.** Formal notice for this hearing has been published simultaneously in the Hartford Courant.

PROPOSAL DESCRIPTION
Eastern Connecticut Health Network, Inc., including its affiliates (collectively, "ECHN") is seeking approval from the Office of Health Care Access ("OHCA") and the Office of the Attorney General, for the proposed transfer of certain of the assets of ECHN, including certain assets of ECHN's two hospitals, Manchester Memorial Hospital and Rockville General Hospital, and ECHN's ownership interests in affiliated entities, to VHS Eastern Connecticut Health System, LLC ("VHS"), a to-be-formed, for-profit entity and joint venture between Tenet Healthcare Corporation ("Tenet") and Yale-New Haven Health Services Corporation ("YNHHSC"). Tenet will own 80% of the membership interests of VHS and YNHHSC will own 20%. The estimated total project cost is $105,000,000, which is subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer.

The transfer will include the operating and other assets of ECHN (other than restricted charitable funds), including the properties, assets and businesses of, or ownership interests of ECHN and its affiliates in the following entities:
- Manchester Memorial Hospital, a licensed general hospital
- Rockville General Hospital, a licensed general hospital
- ECHN Eldercare Services, Inc. (d/b/a Woodlake at Tolland Rehabilitation & Nursing Center), a licensed chronic and convalescent nursing home
- Visiting Nurse and Health Services of Connecticut, Inc., a licensed home health care agency, and its direct subsidiary, A Caring Hand, LLC, a licensed homemaker-companion agency
- Clinically Integrated Network of Eastern Connecticut, LLC
- Connecticut Healthcare Insurance Company, Inc.
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC
- ECHN Enterprises, Inc.
- Haynes Street Property Management, LLC

The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:
- Aetna Ambulance Service, Inc., a licensed EMS organization
- Metro Wheelchair Service, Inc., a licensed EMS organization
- Ambulance Service of Manchester, LLC, a licensed EMS organization
- Evergreen Endoscopy Center, LLC, a licensed ambulatory surgical center
- WBC Connecticut East, LLC, a licensed mental health day treatment provider and psychiatric outpatient clinic
- Northeast Regional Radiation Oncology Network, Inc., a licensed outpatient clinic
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Pathology Laboratory Services, LLC
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
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Finally, the parties will work to restructure ECHN's medical foundation, Eastern Connecticut Medical Professionals Foundation, Inc. (the "ECHN Medical Foundation"). Consistent with Connecticut law, this restructuring will take the form of either (i) a member substitution, pursuant to which Tenet or an affiliate of Tenet will become the sole member of ECHN Medical Foundation; or (ii) a transfer of the assets and liabilities of ECHN Medical Foundation to a new medical foundation, the sole member of which will be Tenet or an affiliate of Tenet.

There are a number of features of the proposed transaction that will benefit the current employees and communities served by ECHN. Although not an exhaustive list, these features will include:
- Operation of ECHN's assets by VHS, a unique partnership between an established for-profit national hospital company and one of the nation's leading academic medical centers.
- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment, maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
- A commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.
- Offers of employment to substantially all ECHN employees with comparable salaries and benefits packages consistent with benefits packages offered to similarly situated employees at other hospitals operated by Tenet in similar markets. Existing bargaining agreements will be assumed and honored for existing terms.
- Maintenance of ownership interest in ECHN's continuum of care network.
- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
- Affiliation with the Yale New Haven Health System, which will provide clinical expertise and aid in comprehensive service line development.
- A commitment to invest $75 million, beyond the estimated project cost, in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff.

No service changes are currently anticipated in connection with the proposed transaction. VHS will continue to provide care to the residents in the service area towns that have historically been served by ECHN including, Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, and Union.

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APPLICATION FOR APPROVAL OF THE PROPOSED ASSET PURCHASE

Eastern Connecticut Health Network, Inc. ("ECHN"), Tenet Healthcare Corporation ("Tenet") and Yale-New Haven Health Services Corporation ("YNHHS") hereby respectfully submit to the Attorney General and the Commissioner of the Department of Public Health the following application for approval of the proposed asset purchase per Conn. Gen. Stat § 19a-486 et seq. and Conn. Gen. Stat. § 19a-630 et seq. (the "Application").

1. **Identify the contact information for ECHN, Tenet, and YNHHS, including the individual(s) to whom the Attorney General and the Department of Public Health shall submit bills for contracts with experts or consultants.**

   Response:

   Tenet Healthcare Corporation:
   Jeffrey Peterson, Senior Counsel
   1445 Ross Avenue
   Suite 1400
   Dallas, TX 75202
   Phone: (469) 893-6104
   Fax: (469) 893-7104

   Email: jeff.peterson@tenethealth.com

   Eastern Connecticut Health Network:
   Dennis P. McConville, Senior VP and Chief Strategy Officer
   71 Haynes Street
   Manchester, CT 06040
   Phone: (860) 533-3429
   Fax: (860) 647-6860

   Email: dmcconville@echn.org

   Yale-New Haven Health Services Corporation:
   Nancy Rosenthal, Senior VP, Health Systems Development
   789 Howard Avenue
   New Haven, CT 06519
   Phone: (203) 688-5721
   Fax: (203) 688-3472

   Email: nancy.rosenthal@greenwichhospital.org

   Bills for contracts with experts and consultants should be sent to the attention of Mr. Peterson.

2. Provide an executive summary of the application for approval.

Response:

This Application is submitted by ECHN, Tenet and YNHHS for approval of the sale of substantially all of ECHN's assets to VHS Eastern Connecticut Health System, LLC ("VHS Eastern CT"). VHS Eastern CT is a to-be formed subsidiary of a planned joint venture regional provider organization, to be known as the Regional Provider, LLC ("Regional Provider"), which will be formed by Tenet and YNHHS. Tenet and YNHHS intend for the Regional Provider to be the vehicle to acquire (subject to all required regulatory approvals) various health care providers, including hospitals in Waterbury, Bristol, Manchester and Rockville, with YNHHS serving as a strong clinical partner.

Pursuant to the terms of the proposed Asset Purchase Agreement (the "Asset Purchase Agreement" or "APA"), VHS Eastern CT will pay $105,000,000 for the assets of ECHN, subject to certain adjustments, including a Net Working Capital reconciliation and reductions for the value of certain ECHN liabilities assumed by VHS Eastern CT and for the value of any joint venture interest that ECHN is unable to assign or transfer. In addition, VHS Eastern CT will commit to spend $75,000,000 on capital items, over five years.

The proceeds from the asset sale will first be used to settle all of ECHN's bond liabilities and other indebtedness and then to fund an indemnity reserve for payment of ECHN liabilities to VHS Eastern CT that may arise post-closing. Any remaining proceeds will be used to settle post-closing liabilities and wind down the operations of ECHN. Following wind down, any remaining funds will be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a community foundation and used to support charitable health related efforts in the wider ECHN community.

ECHN conducted a thorough and extensive process to determine the proposed course of action. Trustees and senior management worked extensively and concluded that affiliation with a larger health system would better position ECHN to be able to continue to meet the health care needs of its communities. A diligent request for proposal and proposal review process led to the decision to sell ECHN's assets to a new joint venture company to be formed by Tenet and YNHHS. Extensive due diligence and a fairness evaluation were completed.

This proposal enables ECHN to move from a small health care system to a large national health care system that offers resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. Tenet will bring the strength of its national system to the service area of ECHN and provide innovation that ECHN could not possibly do independently. Tenet offers both financial strength and health care experience, with the latter further enhanced through its partnership with YNHHS.

For at least three years, VHS Eastern CT will continue to operate both MMH and RGH as acute care hospitals. At closing, Tenet or an affiliate will offer employment to substantially all employees of ECHN and its affiliates. Existing union contracts, medical education

relationships and ownership in post-acute providers will also be maintained. MMH and RGH will each maintain an advisory board of trustees (the "Local Board") made up of community representatives, physicians on the respective hospital's medical staff, and the Chief Executive Officer of the respective hospital. Tenet will establish a new medical foundation that will offer employment to all licensed providers employed by ECHN or its affiliates.

Further description of each of the parties is provided below.

The Parties

ECHN

ECHN is a not-for-profit health care system that serves 19 towns in eastern Connecticut. ECHN was formed in 1995 when MMH and RGH joined as partners. By bringing together the experience and resources of all ECHN health care facilities, ECHN has provided more convenient access to a wider range of health care services, in order to exceed the expectations of the patients and communities it serves.

ECHN's care network consists of a number of wholly owned entities including:

- MMH
- RGH
- ECHN ElderCare Services, Inc.
- Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC")
- A Caring Hand, LLC
- Clinically Integrated Network of Eastern Connecticut, LLC
- Connecticut Healthcare Insurance Company
- ECHN Corporate Services, Inc.
- Medical Practice Partners, LLC
- ECHN Enterprises, Inc.
- Haynes Street Property Management, LLC
- Eastern Connecticut Medical Professionals Foundation, Inc.
- ECHN Community HealthCare Foundation, Inc.

ECHN has ownership interests in a number of community based services including the following joint ventures:

- Evergreen Endoscopy Center, LLC
- WBC Connecticut East, LLC
- Aetna Ambulance Service, Inc.
- Metro Wheelchair Service, Inc.
- Ambulance Service of Manchester, LLC
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Northeast Regional Radiation Oncology Network, Inc.
- Tolland Imaging Center, LLC

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ECHN's mission has been impeded over the last decade by various factors, including reduced reimbursement from government payors, limited access to the capital required to improve infrastructure and to recruit and maintain needed physicians, and mounting pension liabilities. ECHN's financial condition since 2001 has been strained, and the reinstitution of Connecticut's hospital tax in 2011 created an additional financial burden. The combination of these factors led to the Board's decision to consider affiliation options. ECHN's community will be best served with the proposed sale of its assets to Tenet and YNHHS, whereby existing facilities and services will be continued, enhanced and integrated into an evolving health care system of the future.

Tenet

Tenet is a for-profit, investor-owned health care services company founded in 1976. Tenet owns 80 acute-care hospitals in 14 states and approximately 200 outpatient centers in 16 states as well as 6 health plans, 12 accountable care networks and Conifer Health Solutions, LLC, which provides business process solutions to more than 700 hospitals and other clients nationwide.

In 2013, Tenet acquired Vanguard Health Systems, Inc. ("Vanguard"), creating the third largest investor-owned hospital company in the United States. Tenet has expertise and experience in new care delivery models both in hospitals and outpatient settings. Tenet does not provide direct health care services but invests time, talent and capital in local health care networks. Tenet invests in facilities and technology to allow providers to remain competitive and enhance the care provided to communities. Tenet's management services now support value-based performance through clinical integration, financial risk management and population health management. Tenet has participated, either directly or through the experience of Vanguard, in some of the groundbreaking trials established and supported by the Centers for Medicare and Medicaid Services ("CMS") to redesign healthcare to a new model which focuses on value rather than volume.

Tenet is focused on the best performance in terms of clinical quality and safety and offers superior quality and patient services to meet community needs. Tenet has a significant amount of capital to invest which will help improve the quality of health care delivered to ECHN's community residents. Tenet is committed to investing and guiding Connecticut's future health care system.

YNHHS

YNHHS was formed in 1996 to enhance the quality and scope of healthcare services for residents of Connecticut and beyond. With a total licensed bed count of 2,130, YNHHS includes three delivery networks: Bridgeport Hospital, Greenwich Hospital and Yale-New

Haven Hospital, and a medical foundation, Northeast Medical Group. YNHHS has clinical relationships with several other hospitals in Connecticut and numerous outpatient locations throughout the state.

YNHHS' hospitals have achieved national and international recognition for their high standard of patient care, outcomes and service excellence. They have received national and regional awards and accreditations by various organizations including the U.S. News and World Report, the Joint Commission, the American College of Surgeons, National Cancer Institutes and Press-Ganey.

YNHHS is affiliated with Yale University and Yale University's School of Medicine in support of innovations in patient care, medical education and clinical research.

YNHHS is committed to investing in unique solutions to challenges in the Connecticut region. The partnership with Tenet supports YNHHS' goal of providing accessible, patient-centered care in association with local community hospitals throughout the region. YNHHS takes pride not just in its accomplishments, but in a vision that is shared among its partners as it moves healthcare forward.

Conclusion

In conclusion, this proposed sale of ECHN's assets represents an innovative solution to long-standing challenges and offers ECHN's service area residents continued access to ECHN's services and facilities. Many of these services and facilities will be enhanced through capital investments and operating efficiencies. The proposal is financially feasible, ensures and enhances access, and improves the financial health of Connecticut's health care system.

3. Describe the terms of the proposed joint venture between Tenet and YNHHS (the "Joint Venture" or the "New ECHN Hospital").

This section should include, but is not limited to, a financial analysis of the transaction and descriptions of Tenet, YNHHS, the new Joint Venture entity that is to be formed between Tenet and YNHHS, the assets to be transferred pursuant to the Joint Venture, any other possible undertakings of the Joint Venture, and the Joint Venture's expected financial state and proposed governance structure after the transaction.

Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Joint Venture.

Response:

Recognizing the dramatic shift within the Connecticut health care environment and beyond, last year Tenet and YNHHS announced an innovative partnership. Under the terms of the proposed partnership, Tenet and YNHHS have agreed to establish a joint venture to serve as the vehicle pursuant to which they will acquire various health care providers, including

hospitals in Waterbury, Bristol, Manchester and Rockville. YNHHS will be a minority member, but will serve as a strong clinical partner. Through this unique partnership, Tenet can bring extraordinary scale to reduce costs, as well as critical access to capital. At the same time, YNHHS can provide nationally-recognized specialty care that amplifies – but does not replace – existing care in the community.

The terms of the proposed joint venture have not yet been fully negotiated and documents have not yet been drafted. Tenet and YNHHS intend, however, to establish the Regional Provider as a limited liability company that will be owned 80% by VHS of Connecticut, LLC, a subsidiary of Tenet, and 20% by YNHHS. The Regional Provider will in turn have a 100% membership interest in VHS Eastern CT, the entity that will purchase the assets of ECHN.

The Regional Provider is expected to serve as the exclusive vehicle (subject to certain exceptions) of Tenet and YNHHS for the acquisition (through directly or indirectly owned subsidiaries) of any ownership interest in any healthcare facility and provider in Connecticut, New York, Rhode Island and parts of Massachusetts (which may include acute care providers, skilled nursing facilities, ambulatory surgery centers, physician organizations, home health agencies, and other clinical providers). The Regional Provider will be governed by a seven (7) member Board of Managers, five (5) of whom will be appointed by Tenet and two (2) of whom will be appointed by YNHHS, provided that YNHHS will have approval rights related to material decisions. The day-to-day operations of each subsidiary of the Regional Provider will be managed by an affiliate of Tenet pursuant to one or more management services agreements.

4. Describe the terms of the proposed Asset Purchase.

This section should include, but is not limited to, a financial analysis of the transaction (e.g., projected sources and uses of proceeds and the valuations of included and excluded assets) and descriptions of ECHN, the Joint Venture, the assets to be transferred pursuant to the Asset Purchase and any assets excluded from transaction, the assumed and excluded liabilities of the Asset Purchase, and the Joint Venture's other undertakings, including, but not limited to, the commitment to spend $75 million dollars on capital items and a plan to expand or acquire new programs or services.

Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Joint Venture.

Response:

The proposed Asset Purchase Agreement commits ECHN and its affiliates, subject to satisfaction of various conditions, to the sale of substantially all of their assets to VHS Eastern CT, a to-be formed subsidiary of the planned Regional Provider (the joint venture holding company formed by Tenet and YNHHS and described in more detail in the response to Question 3 above). The transaction described in the APA follows largely from the Letter of Intent signed on August 8, 2013 among ECHN, Vanguard Health Systems, Inc. (since

acquired by Tenet), and YNHHS (a copy of which is attached hereto as Exhibit 1). All capitalized terms not defined herein are defined in the APA, a copy of which is attached as Exhibit 2.

1. Description of ECHN

A. ECHN is a not-for-profit health care system that serves 19 towns in eastern Connecticut. It includes both MMH and RGH (MMH and RGH are sometimes referred to herein as the "Hospitals"), as well as a post-acute care continuum of care network, a physician network, and other health care services.

2. Description of VHS Eastern CT

A. VHS Eastern CT will be formed as a Delaware limited liability company that is wholly-owned by the Regional Provider, a joint venture holding company formed by Tenet and YNHHS.

B. Tenet unconditionally guarantees the full, punctual, and complete performance by VHS Eastern CT of all of VHS Eastern CT's obligations under the APA.

3. Form of Transaction

A. VHS Eastern CT will purchase substantially all of the assets of ECHN, including the properties, assets and businesses of, or ownership interests of ECHN affiliates in, the following entities (referred to collectively as the "Hospital Businesses"):

- MMH
- RGH
- ECHN ElderCare Services, Inc.
- Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC")
- A Caring Hand, LLC
- Clinically Integrated Network of Eastern Connecticut, LLC
- Connecticut Healthcare Insurance Company
- ECHN Corporate Services, Inc.
- Medical Practice Partners, LLC
- ECHN Enterprises, Inc.
- Haynes Street Property Management, LLC

B. VHS Eastern CT will also purchase ECHN's interests in the following joint ventures (each an "ECHN Joint Venture," and collectively the "ECHN Joint Ventures"), subject to approval by other members of the ECHN Joint Ventures as may be required by law or the applicable joint venture agreements:

- Evergreen Endoscopy Center, LLC
- WBC Connecticut East, LLC
- Aetna Ambulance Service, Inc.
- Metro Wheelchair Service, Inc.

- Ambulance Service of Manchester, LLC
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.

C. In addition, VHS Eastern CT will purchase ECHN's affiliates' interests in the following joint ventures (each an "ECHN Affiliate Joint Venture," and collectively the "ECHN Affiliate Joint Ventures"), subject to approval by other members of the joint ventures as may be required by law or the applicable joint venture agreements:

- Northeast Regional Radiation Oncology Network, Inc.
- Tolland Imaging Center, LLC
- Pathology Laboratory Services, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

4. Key Assets and Liabilities To Be Acquired by VHS Eastern CT

A. VHS Eastern CT will acquire real property, leased property, equipment, accounts receivable, and net working capital (*i.e.*, non-cash current assets less the value of all current liabilities) of ECHN and the ECHN affiliates. (*See* Exhibit 2, Section 2.01)

B. Key liabilities VHS Eastern CT will assume include ECHN's unfunded pension liabilities, ECHN's health benefit plan for retirees, ECHN's captive insurer liabilities (*i.e.*, Connecticut Healthcare Insurance Company) and ECHN's workers' compensation obligations. (*See* Exhibit 2, Sections 1.01(7), 2.03)

C. ECHN obtained a "fairness evaluation" from Duff & Phelps Corporation valuing the above-listed assets and liabilities. The detail regarding this valuation may be found in response to Question 7 below.

5. Key Assets and Liabilities Excluded from the Transaction

A. VHS Eastern CT will exclude some current ECHN liabilities that will then remain the responsibility of ECHN's residual corporation following the transaction (note that this corporation will primarily serve administrative functions with respect to remaining assets). (*See* Exhibit 2, Section 2.04)

- For example, VHS Eastern CT will not assume liabilities that could arise from lawsuits or tax settlements based on pre-closing activities.

B. VHS Eastern CT will exclude certain assets of ECHN, including certain cash and cash equivalents of ECHN or the Hospital Businesses, as well as restricted assets of ECHN (*e.g.*, donor restricted funds held by the Hospitals and ECHN Community HealthCare Foundation, Inc. will be excluded from the transaction). (*See* Exhibit 2, Section 2.02)

6. Purchase Price and Use of Proceeds

A. VHS Eastern CT will pay $105,000,000 (subject to Net Working Capital reconciliation), *minus* the amount of certain ECHN liabilities assumed by VHS Eastern CT (*e.g.* ECHN's unfunded pension obligations, Captive Insurer Liability, capital leases, and the Workers' Compensation Liability), *minus* asbestos abatement liability of up to $1,000,000, and *minus*, in the event that ECHN is unable to assign or transfer to VHS Eastern CT ECHN's interest in an ECHN Joint Venture or an ECHN Affiliate Joint Venture, any amount ECHN receives from a third party to purchase ECHN's interest in such ECHN Joint Venture or ECHN Affiliate Joint Venture or, in the case that an ECHN Joint Venture interest or ECHN Affiliate Joint Venture interest remains with ECHN following the closing, a dollar amount to be fixed in advance for each ECHN Joint Venture or ECHN Affiliate Joint Venture. Refer to the response to Question 43 for additional information. (*See* Exhibit 2, Section 2.05(a))

B. The proceeds from the asset sale will first be used to settle all of ECHN's bond liabilities and all of ECHN's other indebtedness. (*See* Exhibit 2, Section 2.05(c))

C. Remaining proceeds will next be used to fund an indemnity reserve (the "Reserve") for a period of at least three years (the "Reserve Period") following the closing of the transaction for payment of ECHN liabilities to VHS Eastern CT that may arise post-closing. Any proceeds that remain after settling bond liabilities, settling other indebtedness, and funding the Reserve will be held by the residual ECHN corporation to be used for post-closing liabilities and wind down of operations. (*See* Exhibit 2, Section 9.08)

D. After expiration of the Reserve Period (which may be extended until the fifth anniversary of the closing date in the event of claims arising during the Reserve Period), any funds remaining in the Reserve and not used to pay claims will be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a community foundation and used to support charitable health related efforts in the wider ECHN community.

7. Local Governance

A. Following the closing, MMH and RGH will each maintain an advisory board of trustees, the Local Board, made up of community representatives, physicians on the respective hospital's medical staff, and the Chief Executive Officer of the respective hospital. (*See* Exhibit 2, Sections 1.01(57), 5.18, 5.21)

- The initial members of the Local Board shall include at least five members of ECHN's Board of Trustees immediately prior to the closing and five other individuals identified by ECHN prior to the closing.

- Among other things, the Local Board will serve as a resource for VHS Eastern CT with respect to VHS Eastern CT's investment of the capital commitment described below, assist with maintenance and implementation of a strategic

business plan for the Hospitals, make recommendations for medical staff credentialing at the Hospitals, review and make recommendations regarding the quality assurance program at the Hospitals and assist in issues relating to accreditation for the Hospitals.

- For at least three years after the closing, VHS Eastern CT will collaborate with the Local Board and remaining former hospital staff of ECHN on clinical quality matters to share best practices and establish clinical quality goals and measure progress.

8. Capital Commitment

A. After closing, VHS Eastern CT, in consultation with ECHN and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses. (*See* Exhibit 2, Section 5.18)

B. VHS Eastern CT will commit to spend (or contract to spend) within five years of the closing not less than $75,000,000 (the "Commitment Amount") for the benefit of the Hospital Businesses and for the benefit of the communities surrounding MMH and RGH. These expenditures may include: (i) capital projects, including routine and non-routine capital expenditures for the improvement of ECHN's facilities; (ii) development, expansion, or acquisition of a department, program, service or facility; (iii) upgrades or renovations generally; (iv) deferred maintenance items; and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. For the purpose of determining whether the Commitment Amount has been satisfied, operating leases for (i) buildings or the fit-out or build-out of space used in the provision or support of medical services or (ii) medical equipment with a useful life of more than one year, shall count towards the Commitment amount.

- VHS Eastern CT has the right to defer this commitment beyond a five-year period if the State of Connecticut enacts any legal requirements after closing that discriminate against for-profit hospitals and cause the Hospital Businesses to suffer a decline in EBITDA of more than ten percent in any year on a consolidated basis. To the extent VHS Eastern CT defers this commitment, it shall make available to the public reasonably detailed information to support VHS Eastern CT's position and shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment.

9. ECHN Community HealthCare Foundation, Inc.

A. The assets of ECHN Community HealthCare Foundation, Inc. (the "Foundation") will not be included in the assets purchased by Tenet. It is anticipated that the funds remaining in the Foundation at closing will be transferred to a community

foundation designated by the Office of the Attorney General of the State of Connecticut. See responses to Questions 10 and 11 below for additional information.

10. Employment Matters

A. Tenet or an affiliate will offer employment as of the closing to substantially all employees of ECHN and its affiliates who work at the Hospital Businesses, including employees on approved leaves of absence as of the closing. (*See* Exhibit 2, Section 5.03(a))

B. Tenet or an affiliate will offer the hired employees salaries that are equal to their salaries as of the closing date and benefits packages that are comparable to those offered to similarly-situated employees at other hospitals operated by subsidiaries of Tenet in comparable markets. (*See* Exhibit 2, Section 5.03(a))

C. Tenet or an affiliate will assume and honor ECHN's (and its affiliates') collective bargaining agreements. (*See* Exhibit 2, Section 5.03(d))

11. Commitment to Maintain Key Clinical Operations and Community Support

A. *Operation of Hospitals*: For at least three years after the closing of the transaction, VHS Eastern CT will continue operating the Hospitals in their current locations as acute care hospitals with emergency departments. (*See* Exhibit 2, Section 5.15)

B. *Post-Acute Care*: Also, for at least three years after the closing of the transaction, VHS Eastern CT will maintain an ownership interest in ECHN's current post-acute care continuum of care network (*e.g.*, the service lines currently operated by VNHSC and ECHN ElderCare Services, Inc.) and require any joint venture involved with such post-acute care continuum of care network to maintain appropriate service lines during such three-year period. (*See* Exhibit 2, Section 5.15)

C. *Medical Education*: VHS Eastern CT will maintain and support financially ECHN's University of New England medical student and other health professions teaching programs, as well as ECHN's graduate medical education programs, while operating at a level not to exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by the Centers for Medicare and Medicaid Services. (*See* Exhibit 2, Section 5.17)

D. *Community Benefits*: VHS Eastern CT will also ensure that each Hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies). (*See* Exhibit 2, Section 5.16)

12. Physician Alignment

A. The parties intend for a new medical foundation to be formed for which Tenet plans to provide funding (the "Medical Foundation"). The Medical Foundation will offer employment to all licensed providers employed by ECHN or its affiliates immediately prior to closing. (See Exhibit 2, Section 7.11)

13. Role of YNHHS

A. The Hospital Businesses will be identified by the YNHHS brand after the closing. (*See* Exhibit 2, Section 5.29)

B. YNHHS will provide clinical expertise to the Hospital Businesses and will aid in comprehensive service line development. (*See* Exhibit 2, Section 5.29)

14. Regulatory Approvals

A. Prior to the closing of the transaction, ECHN, Tenet and YNHHS will apply for all necessary regulatory approvals needed to consummate the transactions contemplated in the APA.

- Among the regulatory approvals required are: (i) approval of the Connecticut Attorney General for conversion of the Hospital Businesses from non-profit to for-profit status; (ii) certificate of need approval from the Department of Public Health, Office of Health Care Access; and (iii) antitrust clearance from the Federal Trade Commission.

15. Key Closing Conditions

A. The closing of the transactions contemplated by the APA are conditioned upon their being no material adverse change to the business, assets, liabilities, financial condition or results of operations of ECHN.

B. In addition, the closing is conditioned upon the formation of the Medical Foundation, which will offer employment to licensed providers employed by ECHN or its affiliates immediately prior to closing.

16. Covenant Not to Compete

A. ECHN covenants that for a period five years after the Closing Date, it shall not, directly or indirectly, own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses within a 30 mile radius of each hospital. (*See* Exhibit 2, Section 5.10)

B. ECHN will not be precluded from participating in activities that promote health care services for residents of communities historically served by ECHN's hospitals. (*See* Exhibit 2, Section 5.10)

17. Termination Fee

A. In the event either party (ECHN or VHS Eastern CT) refuses to close the transactions contemplated by the APA, then such "breaching" party shall pay to the other party a termination fee equal to $3,150,000. (*See* Exhibit 2, Section 8.04(b))

18. Termination Prior to Closing

A. The APA may be terminated at any time on or prior to the closing date: (i) by mutual consent of the parties; (ii) by VHS Eastern CT if any event occurs or condition exists which causes ECHN to be unable to satisfy one or more conditions to the obligations of VHS Eastern CT to consummate the transaction; (iii) by ECHN if any event occurs or condition exists which causes VHS Eastern CT to be unable to satisfy one or more conditions to the obligations of ECHN to consummate the transaction; and (iv) by either party if the closing date shall not have taken place on or before May 1, 2015 (though such date may be extended by mutual agreement of ECHN and VHS Eastern CT). (*See* Exhibit 2, Section 8.04(a))

19. Indemnification

A. Subject to certain limitations set forth in the APA, ECHN shall indemnify VHS Eastern CT against: (i) any inaccuracy in or breach of any representation or warranty of ECHN set forth in the APA or in any Closing Document to which ECHN is a party; (ii) any claim against VHS Eastern CT or its Affiliates that, if meritorious, would give rise to a breach of any of ECHN's representations and warranties as the direct cause of such claim; (iii) the nonfulfillment or breach of any covenant of ECHN set forth in the APA or in any other closing document to which ECHN is a party; (iv) excluded Liabilities; (v) any actual damages resulting from claims by a creditor of ECHN that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable law; and (vi) any liabilities, costs or expenses incurred by VHS Eastern CT or its Affiliates in connection with the Connecticut Transfer Act. (*See* Exhibit 2, Section 9.01)

B. Subject to certain limitations set forth in the APA, VHS Eastern CT shall indemnify ECHN against: (i) any inaccuracy in or breach of any representation or warranty of VHS Eastern CT set forth in the APA or in any closing document to which VHS Eastern CT is a party; (ii) the nonfulfillment or breach of any covenant of VHS Eastern CT in the APA or in any Closing Document to which VHS Eastern CT is a party; (iii) the Assumed Liabilities; and (iv) ownership by VHS Eastern CT of the Assets or the operation by VHS Eastern CT of the Hospital Businesses after the Closing Date. (*See* Exhibit 2, Section 9.03)

20. Indemnity Reserve

ECHN agrees to maintain an indemnity reserve in the amount of $7,500,000 for a period of three years after the Closing so that VHS Eastern CT will have meaningful recourse against ECHN for any potential indemnification claims. If certain claims arise during this three year period, the indemnification reserve may be extended, but not beyond the fifth anniversary of the Closing Date. (*See* Exhibit 2, Section 9.08) The indemnification obligations of VHS Eastern CT to ECHN are guaranteed by Tenet. (*See* Exhibit 2, Section 10.23)

5. Describe the due diligence undertaken by ECHN in deciding to enter into the Asset Purchase.

This section should include, but is not limited to, considerations regarding the current financial condition of ECHN and any projected financial condition of ECHN, any professional assessments of or reports regarding ECHN or the Regional Provider, any and all alternatives explored by ECHN or other offers received by ECHN, the reasons for rejecting such alternatives and offers, ECHNs selection of the Regional Provider, and the specific terms of the Asset Purchase.

In addition, the parties should discuss the due diligence in obtaining the fairness evaluation required by Conn. Gen. Stat.§ 19a-486a(c)(5), including providing a copy of said independent expert's resume or other documentation of his or her qualifications and describing the process undertaken to identify and retain this person as an independent expert.

Response:

ECHN's decision to enter into the Asset Purchase Agreement was the result of a lengthy and thorough process, as described in more detail below.

BACKGROUND

ECHN has a long history of providing care in the community, including to a large number of Medicare, Medicaid and uninsured patients. Like many nonprofit community hospitals, ECHN's mission has been impeded over the last decade or so by various factors, including reduced reimbursement from government payors, limited access to the capital required to improve infrastructure and to recruit and maintain needed physicians, and mounting pension liabilities.

In 2001, ECHN lost more than $10 million and continued to operate in the red over the next several years. ECHN's management took various actions to mitigate losses during this time and was able to improve ECHN's financial condition significantly. However, capital investments had to be deferred and long-term debt and pension liabilities continued to grow.

Pension funding reforms and the market crash in 2008 exacerbated ECHN's already delicate financial condition. Hiring freezes, wage freezes, reductions in force, a permanently reduced workweek of 37.5 hours, LEAN program initiatives and group purchasing initiatives were all instituted to respond to ECHN's financial challenges. Despite these measures, a large portion of ECHN's annual cash flow was required to fund debt service and pension obligations, making capital investments difficult. As a result, infrastructure improvements continued to be deferred, as were plans to expand and introduce new programs to help recruit physicians to replace those who were relocating or retiring.

The adoption of the Patient Protection and Affordable Care Act ("PPACA") in 2010 further changed the landscape for health care providers, including ECHN, with significant planned reductions in government payments for services and requirements to participate in new payment models with a focus on collaboration and coordinated care. Then, in 2011, Connecticut reinstituted the hospital tax, putting an even further strain on ECHN's finances. The combination of these factors led to the Board's decision to consider affiliation options.

ECHN ended fiscal year 2011 breakeven from operations and an overall bottom line loss of $1,299,000. This was the first fiscal year impacted by the new State of Connecticut hospital tax. The net revenue reduction to ECHN was over $580,000 for the 4th quarter and the following fiscal year (2012) was impacted by a $2,323,000 revenue reduction. In fiscal year 2012, ECHN also experienced a decline in inpatient and outpatient volumes. In the first half of fiscal year 2012, with the implementation of health insurance exchanges pending, ECHN began to model pro forma projections for the next five years. The projections included anticipated payer mix shifts to the exchanges and Medicaid. For fiscal years 2014 and 2015, the first two years affected by the exchanges, ECHN projected that net revenues would decline by $11,000,000 per year and that ECHN would realize operating losses close to $6,000,000 per year. These significant financial challenges led ECHN management to conclude that future financial viability would require partnering. As ECHN considered partnering options over the next two years, the increases to the state hospital tax, Medicare sequestration, and the continued evolution of the health spending accounts/new consumerism added merit to the position to partner.

ESTABLISHMENT OF PARTNERING WORKGROUP AND DECISION TO AFFILIATE

In September, 2011 the ECHN Board authorized the establishment of a workgroup to study the impact of PPACA on ECHN and to evaluate whether benefits would be realized by affiliating with another health care system, or whether ECHN would better serve the community by remaining an independent system.

The workgroup (the "Partnering Workgroup" or the "Affiliation Subcommittee") was assembled in November, 2011 and included Trustees, Corporators, Medical Staff members and key executives. To assist the Partnering Workgroup in its evaluation, ECHN engaged The Chartis Group, LLC ("Chartis"), a national healthcare consulting firm. Background regarding Chartis and the Chartis team is included in Exhibit 3. With the help of Chartis, the Partnering Workgroup tasked itself with considering the issues set forth below:

Affiliation Subcommittee Composition and Role	
AFFILATION SUBCOMMITTEE	ROLE OF THE SUB-COMMITTEE
• Dr. Dennis O'Neill – Board Chair • Dr. Angelee Carta • Dr. Anthony DiStefano • Ms. Joy Dorin • Mr. Jeffrey Heidtman • Mr. Joseph Jeamel, Jr. • Mr. Peter Karl • Dr. Pamela Lewis • Mr. Dennis McConville • Ms. Robin Murdoch-Meggers • Dr. Claudio Milite • Dr. Saqib Naseer • Ms. Rosemary Papa • Dr. Joel Reich	• Guide affiliation planning process • Determine if some form of affiliation would be helpful • Develop Vision and Goals for such an affiliation • Assess benefits & risks of potential affiliation options / partners • Define recommended partnership structure and terms • Ensure appropriate communication and engagement with key constituencies • Seek concurrence of full Board at appropriate intervals

The Partnering Workgroup began its study in earnest in December, 2011 and met numerous times over the next several months. In addition to evaluating local and national data, the Partnering Workgroup met with key constituents (community and Board members, physicians, management and staff) and with prospective partner organizations to obtain their perspectives on ECHN, its current state and its future.

On September 22, 2012, the Partnering Workgroup presented its initial findings to the ECHN Board. The Partnering Workgroup concluded that affiliation with a larger health system would better position ECHN to achieve the following goals: (i) attract patients and providers based on quality, service, accessibility and affordability; (ii) enhance physician retention and recruitment; (iii) improve ECHN's financial position in order to invest in new equipment and technologies; and (iv) coordinate care to manage risk and participate in new payment vehicles.

In light of this conclusion, the Partnering Workgroup identified several potential partners, including nonprofit and for-profit health systems, and developed a set of key criteria to be considered when evaluating partners. Criteria included: (i) cultural compatibility with that of ECHN; (ii) strategic and financial fit; (iii) organizational strength and capabilities; and (iv) risks of implementation.

Following the presentation of the Partnering Workgroup, the Board voted to pursue an affiliation and tasked the Partnering Workgroup with further evaluating how potential partners could further ECHN's goals and developing key affiliation terms.

EVALUATION OF PROPOSALS BY AFFILIATION SUBCOMMITTEE

In the fall of 2012, the Partnering Workgroup worked with Chartis to develop a request for proposal (RFP) for submission to potential partners. On November 21, 2012, the RFP and proposed recipients were presented to the Board for review and comment.

On November 26, 2012, the RFP was mailed to three (3) nonprofit health systems and three (3) for-profit health systems. Copies of the RFPs delivered to YNHHS and to Vanguard Health Systems, Inc. ("Vanguard") are attached as Exhibit 4 (the RFPs delivered to the other potential partners were in substantially the same form as the RFPs delivered to YNHHS and Vanguard).

Potential partners were provided with limited confidential due diligence information regarding ECHN and were asked to submit non-binding Indications of Interest by mid-January, 2013. Indications of Interest were to include a detailed proposal, including the following:

1. Proposed form or structure of affiliation (e.g., merger, acquisition of assets, member substitution or joint venture).

2. Financial terms of affiliation, including proposed treatment of ECHN's existing debt, consideration, and future capital commitments.

3. How the affiliation would help ECHN to achieve its vision and goals, with a focus on access to care, medical staff integration, clinical quality, safety, service and patient satisfaction.

4. Proposed governance and management structure.

5. Plans for retention of employees.

6. Commitments to continuing and expanding services.

7. Proposed timing, required regulatory approvals, and material contingencies.

By January 15, 2013, four (4) Indications of Interest were received. One (1) Indication of Interest was from a nonprofit health system that proposed a management relationship with ECHN; the remaining three (3) Indications of Interest were from joint ventures between nonprofit and for-profit health systems proposing to acquire all or substantially all of the assets of ECHN, including the proposed joint venture between YNHHS and Vanguard.

The Indications of Interest were evaluated by the Partnering Workgroup on January 24, 2013 against the selection criteria approved by the Board. Members of the Partnering Workgroup then met with each respondent for further detail on the proposals submitted and followed up with formal requests for clarification/additional information on February 23, 2013.

Following receipt of responses to the requests for clarification/additional information, a second round of meetings was held with the respondents in March, 2013. Site visits were also conducted in some cases, including a site visit to a Vanguard-affiliated hospital in Massachusetts.

In April 2013, the Partnering Workgroup evaluated each of the proposals received by considering the following questions:

1. a. How would an ECHN partnership with this organization help improve the convenience, quality, accessibility and affordability of care in the community?

   b. What are the risks inherent in achieving the above?

2. a. How would an ECHN partnership with this organization help ECHN achieve its strategic objectives (be the provider of choice east of the Connecticut River; provide a full spectrum of services; improve finances; increase capabilities to manage population health and risk/incentives)?

   b. What are the risks inherent in achieving the above?

3. How closely aligned is the potential partner with ECHN for structural and cultural fit?

4. How would you rate their strategy to succeed in the future?

5. How would you assess their organizational strength?

6. What is their willingness to invest locally?

7. What do you think are greatest advantages of entering into some form of affiliation with this organization/partnership?

8. What do you see as the greatest risks or concerns in entering into some form of affiliation with this organization or partnership?

9. What other information will you want to see and what issues would you like to see addressed before making a final recommendation?

10. Which affiliation option is likely to be the most successful in the market in your opinion – and why?

11. If you were asked to make a recommendation in favor one or two of these affiliation options right now, which one(s) would you favor – and why?

ESTABLISHMENT OF BOARD TRANSACTION COMMITTEE

The findings of the Partnering Workgroup were summarized by Chartis and a formal presentation was made to the Board on April 27, 2013. The Board was asked to consider both (i) whether the proposals made would meet ECHN's needs; and (ii) whether other

options should be considered. The Board was also asked to consider requesting additional information from the respondents. The Board determined that other alternatives were unlikely and that further evaluation should be undertaken regarding the proposals presented to date. Accordingly, at the April 27, 2013 Board meeting, the Board authorized the creation of a formal Board Transaction Committee to further evaluate the work of the Partnering Workgroup and conduct additional diligence regarding the proposals submitted.

EVALUATION OF PROPOSALS BY TRANSACTION COMMITTEE

On May 3, 2013, ECHN requested "best and final" Indications of Interest from each of the prior respondents to the RFP. Responses were received in late May from all respondents, but one (1).

On May 30, 2013, the Transaction Committee met with members of the Partnering Workgroup to review the remaining Indications of Interest and the work of the Partnering Workgroup in evaluating each over the preceding twenty (20) months. At the meeting, the summary attached as Exhibit 5 was reviewed.

The Transaction Committee held additional meetings on June 5 and 10, 2013. At the meetings, the Transaction Committee carefully considered all of the proposals and evaluated their benefits and risks. The Transaction Committee also reviewed "reverse due diligence" information prepared by Chartis on the proposed acquirers, including information regarding financial condition, leadership, strategic focus, quality indicator trends, and clinical programs.

Ultimately, the Transaction Committee made a preliminary finding that the YNHHS and Vanguard proposal was superior to the other proposals received for various reasons, including (i) the fact that the proposed consideration would cover ECHN's liabilities, both for debt and pension, and result in remaining funds to be transferred to a community foundation; (ii) their willingness to assume ECHN's pension liability (with an adjustment to the purchase price); (iii) the cultural fit among the parties; and (iv) YNHHS's strong clinical expertise and brand. The Transaction Committee, however, determined that additional information should be obtained from the respondents before a final recommendation was submitted to the Board, which was requested and received.

SELECTION OF AFFILIATION PARTNER

On June 12, 2013, the Transaction Committee reviewed final information from the respondents and made its recommendation and report to the Board. Topics reviewed and discussed at the special meeting of the Board held on June 12, 2013 included: financial projections for ECHN; a review of the goals, vision and partner selection criteria for affiliation; evaluation and comparisons of the proposals; a "net proceeds" analysis of the bids; antitrust considerations for the proposals; uncertainties and risks of decisions relating to charitable assets, impacts on ECHN joint venture interests, medical staff acceptance, community concerns and competitive concerns; the mechanics, tasks and timeline for a transaction; and due diligence performed on the potential acquirers.

The recommendation of the Transaction Committee was to proceed with negotiating a term sheet and draft letter of intent with YNHHS and Vanguard. The Board considered and approved the recommendation of the Transaction Committee.

NEGOTIATION OF LETTER OF INTENT; ACQUISITION OF VANGUARD BY TENET

On June 17, 2013, ECHN received a draft Letter of Intent from YNHHS and Vanguard. The following week, on June 24, 2013, ECHN was informed by Vanguard that it was to be acquired by Tenet, but that Tenet intended to proceed with negotiating a letter of intent for the acquisition with ECHN.

ECHN began its due diligence of Tenet with a review of publicly available bank and credit reports. Additional nonpublic information was requested, as well as a visit to a Tenet hospital and a meeting with Tenet leadership. On July 2, 2013, Dennis O'Neill, M.D., Chairman of the Board, Peter Karl, President and CEO, Eric Kloter, Trustee and Dennis McConville, Senior Vice President visited Tenet's Good Samaritan Hospital in Palm Beach, FL. They were joined by representatives of both Vanguard and Tenet, as well as members of Good Samaritan Hospital's Medical Staff Leadership and Board. Topics discussed included the role of the advisory board, the approach for strategic planning, investments and operations by region, medical staff relations, quality initiatives and patient satisfaction, employee engagement and satisfaction. The consensus of the ECHN team was that the organization was well positioned and well run with a focus on patients, the community and medical staff relationships.

On July 22, 2013, the ECHN Transaction Committee met in New Haven with representatives of YNHHS, Vanguard and Tenet. Tenet's CEO described the vision for the Tenet-Vanguard transaction and their plans for Connecticut. A key topic of discussion was Tenet's compliance history. ECHN was assured that changes were made to the governance and executive leadership of Tenet and that Tenet had been rebuilt with an acute focus on compliance.

APPROVAL OF LETTER OF INTENT; NEGOTIATION OF ASSET PURCHASE AGREEMENT

On July 31, 2013 the ECHN Board of Trustees considered the diligence review of Tenet and the Letter of Intent and further discussed whether potential alternatives should be explored. Following discussion, the Board approved the Letter of Intent and authorized management, in consultation with the Transaction Committee, to proceed to negotiation of a definitive Asset Purchase Agreement.

The Letter of Intent among ECHN, YNHHS and Vanguard was executed on August 8, 2013. Promptly following its execution, the parties conducted confirmatory diligence and commenced negotiations of the Asset Purchase Agreement.

Negotiations concluded in the spring of 2014 and the Asset Purchase Agreement was presented to the Board for approval on April 9, 2014. At the meeting, the terms were reviewed in detail and a fairness valuation was presented by Duff & Phelps. Following discussion of the proposed transaction and further consideration of alternative proposals

presented to ECHN, the Board unanimously approved the Asset Purchase Agreement in substantially the form presented.

The Asset Purchase Agreement was then submitted to ECHN's Corporators for consideration. The ECHN Corporators approved the Asset Purchase Agreement on May 12, 2014. A total of 190 Corporators voted in person or by proxy, with 172 voting in favor of the transaction and 17 against (1 Corporator recused himself/herself from the vote), a 91% favorable vote (Exhibit 6).

Please see Applicants' response to Question 7 for a description of the diligence undertaken to identify the expert giving the fairness valuation.

6. **Describe any and all potential conflicts of interest between, among, or pertaining to, at a minimum, any and all board members, officers, key employees, and experts of ECHN, Tenet, YNHHS, any other party to the transaction, and any person or entity that performed assessments requested in this application.**

In addition, describe the due diligence taken to determine the existence of any conflicts of interest, including how ECHN, Tenet, and YNHHS defined "conflict of interest" for purposes of the response to this question.

Response:

Conflict of Interest/Financial Disclosure forms (the "Disclosure") were prepared and disseminated to (i) those individuals who were members of the Board of Trustees of ECHN, MMH, RGH, ECHN Eldercare Services, Inc., and Visiting Nurse and Health Services of Connecticut, Inc. at any time during the period from the date the transaction was initially contemplated through the filing of this application; (ii) experts consulted with respect to the transaction; and (iii) the senior executives of ECHN, YNHHS and Tenet who have direct involvement in the transaction. The Disclosure required responses with respect to any financial interests, beneficial interest and/or employment interest in the proposed transaction and/or any entity associated with the principals involved in the transaction. The Disclosure also required statements regarding Related Persons, defined as:

> *"A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent."*

The completed Disclosures for ECHN are attached as Exhibit 7. The completed Disclosures for Tenet are attached as Exhibit 8. In addition, Tenet relied on the conflict of interest self-reporting requirements applicable to all members of its Board of Directors as set forth in Paragraph 11 of the Tenet Healthcare Corporation Corporate Governance Principles, a copy

which is attached as Exhibit 9. The completed Disclosures for YNHHS are attached as Exhibit 10.

The ECHN Board of Trustees performed extensive due diligence and an in-depth analysis of Trustee relationships for transaction-related conflicts of interest. This process began in March 2013 when the Chairman of the Board of Trustees of ECHN created an ad hoc Conflict of Interest Task Force (the "Conflict of Interest Task Force") to which he appointed three independent Trustees. The Conflict of Interest Task Force met actively throughout the spring and summer of 2013 to review applicable statutory, regulatory and organizational conflict of interest requirements and evaluate the status of each Trustee with respect to those requirements, with particular focus on the financial relationships, if any, that each Trustee had with ECHN and any potential bidders and conflicts that might be raised by the Board's consideration of a potential partnering transaction. This process included a review of all contracts, employment relationships and family member relationships that any Trustee had with ECHN or any bidder under consideration, along with reviews of prior completed annual conflicts disclosure forms and a specific disclosure form developed in anticipation of the transaction. As a result of this work, the Conflict of Interest Task Force recommended, and on May 29, 2013 the Board adopted, a two-step process for voting on transaction related resolutions so as minimize the potential for any personal interest to impact the ultimate vote on these matters. In the first step, those Trustees having a conflict of interest would be recused, and the remaining Trustees (both independent and non-independent under the IRS Form 990 "independence" test) would confer and vote on transaction related resolutions. In the second step the non-independent Trustees would be recused and the independent Trustees would separately confer and hold a second vote on the transaction related resolutions.

This two-step voting process was used at the time the Trustees voted to negotiate a letter of intent with Vanguard and YNHHS on June 12, 2013, and at the time the Trustees voted to approve the terms of the APA on April 9, 2014. During the June 12, 2013 vote, three of the twenty then-sitting Trustees voluntarily recused themselves from voting on the basis of conflicts (two of them due to family relationships with individuals working for one of the bidders, and one due to existing contractual relationships with some of the bidders) and seven voluntarily recused themselves from voting in the second vote under the independence test due to employment with ECHN (the CEO) or as physicians having a contractual relationship with ECHN. During the April 9, 2014 vote one of the nineteen then-sitting Trustees voluntarily recused himself due to an existing contractual relationship with a bidder, and seven voluntarily recused themselves from voting in the second vote under the independence test due to employment with ECHN (the CEO) or as physicians having a contractual relationship with ECHN. In all instances, including the votes by the independent Trustees, the votes were unanimous in favor of proceeding with the transaction.

Additionally, on April 27, 2013 the Board ratified the appointment of a Transaction Committee with independent Trustees as its majority in order to evaluate the potential transaction from a disinterested perspective during the negotiation process. The Transaction Committee met numerous times throughout that process in order to evaluate the fairness of the transaction terms for ECHN, and had the role of evaluating and recommending the terms to the full Board for approval before its vote. (See response to

Question 5, above, for additional information on the process of review undertaken by the Transaction Committee.)

For purposes of their conflict of interest determinations during this period of time, the ECHN Conflict of Interest Task Force and the Board of Trustees utilized the "conflict of interest" standards set forth in the Connecticut Revised Nonstock Corporation Act, as required by the ECHN Bylaws and the ECHN Conflict of Interest Policy, and specifically Connecticut General Statutes Chapter 602, Nonstock Corporations, § 33-1127(f), "Directors' Conflicting Interest Transactions", and § 33-1003a, "Qualified Director", including but not limited to the following definitions:

> **"Director's conflicting interest transaction"** means a transaction effected or proposed to be effected by the corporation, or by an entity controlled by the corporation, (A) to which, at the relevant time, the director is a party, (B) respecting which, at the relevant time, the director had knowledge and a material financial interest known to the director, or (C) respecting which, at the relevant time, the director knew that a related person was a party or had a material financial interest.
>
> **"Material financial interest"** means a financial interest in a transaction that would reasonably be expected to impair the objectivity of the director when participating in action on the authorization of the transaction.

Furthermore, the ECHN Board of Trustees evaluated the relationship between each Trustee and ECHN utilizing the definition of "independence" set forth in the 2012 instructions to IRS Form 990, as follows:

> **Independent voting member of governing body:** A voting member of the governing body if all four of the following circumstances applied at all times during the organization's tax year.
>
> 1. The member was not compensated as an officer or other employee of the organization or of a related organization (see the instructions for Schedule R, Related Organizations and Unrelated Partnerships), except as provided in the religious exception discussed in the Instructions for Form 990, Part VI.
>
> 2. The member did not receive total compensation or other payments exceeding $10,000 during the organization's tax year from the organization or from related organizations as an independent contractor, other than reasonable compensation for services provided in the capacity as a member of the governing body. For example, a person who receives reasonable expense reimbursements and reasonable compensation as a director of the organization does not cease to be independent merely because he or she also receives payments of $7,500 from the organization for other arrangements.
>
> 3. Neither the member, nor any family member of the member, was involved in a transaction with the organization (whether directly or indirectly through

affiliation with another organization) that is required to be reported on Schedule L (Form 990 or 990-EZ) for the organization's tax year.

4. Neither the member, nor any family member of the member, was involved in a transaction with the organization (whether directly or indirectly through affiliation with another organization) required to be reported on Schedule L (Form 990 or 990-EZ) Transactions with Interested Persons, for the organization's tax year.

A member of the governing body is not considered to lack independence merely because of the following circumstances.

1. The member is a donor to the organization, regardless of the amount of the contribution.

2. The member has taken a *bona fide* vow of poverty and either (a) receives compensation as an agent of a religious order or a section 501(d) religious or apostolic organization, but only under circumstances in which the member does not receive taxable income (see Rev. Rul. 77-290, 1977-2 C.B. 26; Rev. Rul. 80-332, 1980-2 C.B. 34) or (b) belongs to a religious order that receives sponsorship or payments from the organization that do not constitute taxable income to the member.

3. The member receives financial benefits from the organization solely in the capacity of being a member of the charitable or other class served by the organization in the exercise of its exempt function, such as being a member of a section 501(c)(6) organization, so long as the financial benefits comply with the organization's terms of membership.

Finally, the Trustees relied on the provisions of the ECHN Bylaws and the ECHN Conflict of Interest Policy, which are consistent with the above standards.

7. Provide an assessment of the fair market value of the transaction, including, but not limited to, a discussion regarding whether the fair market value of ECHN's assets has been manipulated.

Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

Response:

ECHN engaged Duff & Phelps to opine as to the fairness, from a financial perspective, of the consideration to be received regarding the sale of ECHN's assets and assumption of certain liabilities. Duff & Phelps is a national and global provider of fairness opinions, with a dedicated healthcare practice. Duff & Phelps' qualifications and conflict disclosure are provided in Exhibit 11, and the scope of engagement is provided in Exhibit 12. The extent of Duff & Phelps' role in the transaction was limited to the performance of the analysis/evaluation of the transaction in rendering the fairness opinion and payment for services was a fixed fee. In conducting the engagement, Duff & Phelps evaluated the proposed terms of the sale and what ECHN would receive in consideration. They considered the historical financial performance and probable future financial performance to determine a fairness range for the gross and net purchase price. The proposed transaction was compared to both gross (estimated enterprise value) and net (enterprise value less assumed liabilities) fairness ranges. The Duff & Phelps Fairness Analysis and Fairness Opinion Letter are included as Exhibits 13 and 14.

With regard to whether or not ECHN's assets were "manipulated" in providing the assessment of the fair market value of the transaction, Duff & Phelps adhered to their model in evaluating ECHN's acquisition price and net proceeds based on market multiples and discounted cash flows. Both ranges of fairness relating to these two approaches were nearly aligned and they were weighted 50/50 in determining the final fairness range for the acquisition of ECHN.

ECHN consulted with Ropes & Gray, its transaction counsel, to obtain firm recommendations for pursuit of a fairness evaluation. Additional firm recommendations were provided by the Chartis Group. In total, five firms were solicited for bids to provide a fairness evaluation/opinion including: Goldman Sachs, DGA Partners, Cain Brothers, Duff & Phelps, and Principle Valuation. Duff & Phelps was selected based on their solid reputation in the healthcare fairness marketplace and a strong recommendation from ECHN's transaction counsel. ECHN had also received documentation from Duff & Phelps regarding their experience in independent service rankings.

8. **Provide an assessment of whether the transaction will place ECHN's assets, including but not limited to, Manchester Memorial Hospital and Rockville General Hospital, at unreasonable risk.**

Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Response:

ECHN's assets will not be placed at unreasonable risk. Rather, ECHN's assets will be strengthened by the acquisition. Tenet is a $17 billion revenue healthcare organization and has the financial capacity to provide the capital necessary for this transaction. Please see Exhibit 15 for Tenet's 2013 10-K and Exhibit 16 for Tenet's 2014 2nd quarter 10-Q, which demonstrate Tenet's strong financial position. Please also see the response to Question 7 for additional discussion on the issue of the Fairness Evaluation. The fairness opinion states that the transaction does not have a financing contingency (Refer to Exhibit 14, previously referenced).

9. **Provide an assessment of whether any managerial contracts to be entered into are for reasonable fair value.**

Provide copies of the managerial contracts and of all documents and statements, financial and otherwise, in support of the fair value assessment.

Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Response:

A management contract between VHS Eastern CT and Tenet (or an affiliate) has not yet been drafted. The contract will address Tenet's (or its affiliate's) responsibilities to manage the day-to-day operations of VHS Eastern CT, including, but not limited to: executing contracts; hiring employees; and buying, selling or leasing real or personal property.

10. **Describe the entity to which the fair market value of ECHN's assets will be transferred including the funding of the entity, its corporate structure, governance and membership, and the charitable purpose of the entity.**

Provide copies of any documents related to the creation, structure, and purpose of the entity.

Response:

At present, ECHN is planning to establish a new charitable entity ("New Foundation") to receive the net proceeds and other assets remaining in ECHN after payment of its liabilities.

Structure, Governance, and Membership. The contemplated structure, governance, and membership, which are in the process of development, are as follows:

- The New Foundation will be a nonstock corporation exempt under section 501(c)(3) of the Internal Revenue Code (the "Code").

- It will be governed by a Board of Trustees of approximately 10 to 20 Trustees who reside or work in the communities previously served by ECHN. The Board is expected to include individuals knowledgeable about, among other things, health care services and community needs, investment, and grant making. Trustees will serve staggered terms of 3 or 4 years and may serve two terms, after which they may not be reelected to the Board until one year has passed.

- The New Foundation will be structured to meet the Code requirements to be a "public charity" (and not a private foundation) as a Type 1 supporting organization under section 509(a)(3) of the Code. At least a majority of the Board of Trustees of the New Foundation will be appointed by local organizations that are themselves section 501(c)(3) public charities or other organizations, such as municipalities, that are treated as public charities for this purpose. At this time, the specific organizations or municipalities that will each have the right to appoint one Trustee have not yet been determined. To achieve a well-rounded board, it is possible that some Trustees will be elected by the New Foundation Board of Trustees as a self-perpetuating component of the Board.

- Independence. To insure that all Trustees are independent of ECHN and the purchaser, the following individuals will not be eligible to serve on the initial Board or subsequent Boards of the New Foundation:

  - Current members of the governing boards of ECHN, MMH, RGH, and any ECHN affiliate until at least two years after the date of the closing and after their service on the board(s) in question has ended;

  - Employees of ECHN, MMH, RGH, and any ECHN affiliate until at least two years after their employment has ended;

  - Individuals who after the closing are on the governing board of any ECHN-affiliated entity, including but not limited to ECHN itself (as the ECHN Legacy corporation) or one of the two local (or advisory) boards for the post-closing hospitals, for at least two years after their service on the board(s) in question has ended; and

  - Individuals who are on the governing board of or employed by the Regional Provider, one of its two members (YNHHS or Tenet), or an affiliate of one of the members for at least two years after their service on the board in question or employment, as the case may be, has ended.

  Individuals who have served as Corporators of MMH and RGH will be eligible to serve on the Board of the New Foundation as long as they were not on one of the governing boards mentioned above or employed by one of the entities mentioned above within the past two years.

An individual who is on the Board of the New Foundation and who either becomes a member of the governing board or an employee of the Regional Provider, one of its two members, or an affiliate of one of the members will be deemed to have resigned from the Board.

The organizations that appoint at least a majority of the Trustees will not be members of the New Foundation and will not have the right to vote on amendments to the Certificate of Incorporation or bylaws.

Purpose. The charitable purpose of the New Foundation will be to promote the health-related and health education-related purposes of the appointing charities and the health of the 19 communities served by ECHN. The New Foundation's purposes will include engaging in activities to assess community needs and providing grants and resources to organizations, projects, or activities that promote health, including the health of underserved populations and care to populations that are unable to pay. At present it is not contemplated that the New Foundation will engage in operating activities, but it is possible that it might do so in the future.

Assets. The New Foundation will receive the proceeds remaining in ECHN after the Asset Purchase and after payment of the liabilities that are being retained by ECHN. In addition, ECHN contemplates that the New Foundation will receive all, or substantially all, the restricted charitable funds remaining in MMH, RGH, and any other ECHN affiliated entities. Transfer of these restricted charitable funds will, in most cases, be accomplished through an equitable deviation or cy pres proceeding authorizing the transfer to New Foundation and modifying, to the extent necessary, donor imposed restrictions to permit use of the funds in the future.

The New Foundation might also be the beneficiary of income from one or more trusts held by outside trustees that were established for the benefit of MMH or RGH; this will depend on the terms of the individual trust documents as well as judicial review and authorization.

Finally the New Foundation will also receive any funds that remain in the indemnity reserve as of the third anniversary of the closing if there are no claims pending against the reserve, or, alternatively, after the resolution of pending bona fide claims.

At this time, the estimated value of the funds that will be transferred to the New Foundation, including restricted funds, is undetermined.

Other Issues. At present, ECHN is consulting with community leaders and organizations to identify those organizations that will have the right to appoint a Trustee of the New Foundation. The Certificate of Incorporation and bylaws of the New Foundation have not yet been prepared, but ECHN expects that the final structure and corporate documents will be in place by early spring of 2015, at which time the New Foundation will prepare and submit Form 1023, Application for Recognition of Exemption, to the Internal Revenue Service. The New Foundation may not receive its determination letter from the IRS for an extended period of time after it files the Form 1023; at present, ECHN does not intend to

transfer any assets or restricted funds to the New Foundation until it has received its determination letter from the IRS.

The Boards of ECHN, MMH and RGH have begun reviewing the contemplated structure but have not yet considered it in detail, and they will do so in the future.

11. Identify any and all assets of ECHN that are subject to a charitable use restriction imposed by a donor and the intended handling of those assets as a result of the Joint Venture.

Please provide a listing of these assets in Microsoft Excel format.

Also, please provide copies of the original gift instruments for each gift identified.

Response:

Assets subject to a charitable use restriction are held by four corporations: Manchester Memorial Hospital ("MMH"), Rockville General Hospital ("RGH"), ECHN Community HealthCare Foundation ("Foundation"), and ECHN ElderCare Services ("Woodlake at Tolland").

CLASSES OF FUNDS

The classes of charitable assets they hold are described below.

ENDOWMENT FUNDS

Unrestricted Endowment Funds

The unrestricted endowment funds are those funds subject to a donor restriction that income only may be spent for the general purposes of the charitable entity in question. They are "not wholly expendable by the institution on a current basis under the terms of a gift instrument" and are therefore endowment funds as defined by the Connecticut Uniform Prudent Management of Institutional Funds Act ("CUPMIFA").

Restricted Endowment Funds

The restricted endowment funds are those funds subject to a donor restriction that income only may be spent and that the income may only be spent for the specific purpose designated by the donor. These funds also are "not wholly expendable by the institution on a current basis under the terms of a gift instrument" and are therefore endowment funds as defined by CUPMIFA.

> **Free Bed Funds.** MMH and RGH hold a special category of endowment funds known as "free bed funds." These funds, which were typically established by donors many years ago to provide care to individuals who could not afford to pay for care, continue to be held with their income restricted to provide free care. These funds are also governed by Section 19a-509b of the General Statutes.

Preservation of Endowment Funds

As stated on their audited financial statements, MMH, RGH, and the Foundation interpret CUPMIFA as requiring the preservation of the fair market value of the original gift or bequest as of the date of the gift absent explicit donor stipulations to the contrary. They therefore classify as permanently restricted net assets (a) the original value of the gift donated to an endowment fund, (b) the original value of subsequent gifts to the endowment fund, and (c) accumulations to the endowment fund made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added. The remaining portion of an endowment fund that is not classified as permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the governing board of the institution consistent with the standard of prudence prescribed by CUPMIFA.

FUNDS SUBJECT TO USE RESTRICTION (SPECIAL PURPOSE FUNDS)

These are fully expendable funds held subject to a "use restriction" imposed by the donor. MMH, RGH, the Foundation, and Woodlake at Tolland believe there are some special purpose funds that they will not be able to use for the designated purposes prior to the Closing. In some cases, that may be because the funds are subject to obsolete, wasteful or impracticable restrictions.

UNRESTRICTED FUNDS

These are fully expendable funds held by the institution that (1) its governing board has determined will be held as endowment for its use or (2) are generally unrestricted by donors or the board. Although such funds could include fully expendable funds subject to a use restriction (e.g., funds being saved for a capital project), ECHN does not at present have any such funds. The board designated and unrestricted funds are not subject to any donor restriction on use (other than use for the institution's general charitable purposes) and, in the discretion of the governing board, can be spent for general charitable purposes.

MISCELLANEOUS FUNDS

MMH is the beneficiary of a major bequest from an estate currently pending in the probate court; at this point, no distributions have been received, and the value of MMH's interest is unknown. RGH and the Foundation have three charitable gift annuities, and there is one life insurance policy.

TRUSTS HELD BY OUTSIDE TRUSTEES

Both MMH and RGH are the income beneficiaries of various trusts held by third party trustees and receive periodic distributions from those trusts. In most cases the trust instrument does not include an alternative disposition in the event the Hospital in question ceases to exist.

DETAIL ON SPECIFIC FUNDS

Detailed information about individual funds held by or for the benefit of ECHN is provided on three attached Excel spreadsheets labelled Exhibits 17, 18, and 19.

Exhibit 17 – ECHN: Endowment and Other Charitable Funds. Exhibit 17 includes information on all funds except for some Special Purpose Funds and Trusts Held by Outside Trustees. The funds on Exhibit 17 are organized by entity, with MMH's funds listed first, followed by those of RGH and then those of the Foundation. Notably, most funds recorded on the books of the Foundation were in fact left by the donors to MMH and RGH but were transferred to the Foundation to be held for the benefit of the Hospital in question. These funds are reported here as Foundation funds, but it is contemplated that they will be transferred back to MMH and RGH prior to the Asset Purchase. Fund balances are reported as of 9/30/14.

Table 1: Summary of Endowment & Other Charitable Funds
(Fair Market Values as of 9/30/14)

Manchester Memorial Hospital	
Endowment: Unrestricted Income	$ 9,609,344
Endowment: Free Bed Funds	$ 1,121,760
Endowment: Restricted for Other Purposes	$ 71,043
Special Purpose Funds	$ 437,544
Unrestricted Funds	$ 34,368
Miscellaneous: Cash Value Life Insurance	$ 55,638*
Total	$ 11,329,697

Rockville General Hospital	
Endowment: Unrestricted Income	$ 8,996,059
Endowment: Free Bed Funds	$ 337,784
Endowment: Restricted for Other Purposes	$ 383,993
Unrestricted Funds	$ 2,820,255
Miscellaneous	$ 0.00*
Total	$ 12,538,090

ECHN Community HealthCare Foundation, Inc.	
Endowment f/b/o MMH: Unrestricted Income	$ 1,285,023
Endowment f/b/o RGH: Restricted Income	$ 282,289
Miscellaneous	$ 0.00*
Total	$ 1,567,312
Grand Total	$ 25,435,099

* Notes re Miscellaneous Lines. The $55,638 reported in Miscellaneous is the current cash value of one life insurance policy donated to Manchester Memorial Hospital. No current asset values are reported for charitable gift annuities or an interest in a new estate.

Exhibit 18 – ECHN: Special Purpose Funds. Exhibit 18 includes information about those Special Purpose Funds that ECHN believes may not be able to be spent or applied prior to the Closing. This chart consolidates the information for all four corporations and reports fund balances as of 9/30/14. This Exhibit does not include information about (1) the special purpose funds that ECHN believes will be spent or (2) one large fully expendable fund subject to a use restriction that is reported on Exhibit 17. The market value of these funds on 9/30/14 is $86,797.

Exhibit 19 – ECHN: Trusts Held by Outside Trustees. Exhibit 19 includes information about the Trusts Held by Outside Trustees for the benefit of MMH or RGH; the funds on Exhibit 19 are organized by entity, with trusts f/b/o MMH listed first, followed by those f/b/o RGH. The market value of these outside trusts on 9/30/14 is $11,809,214.

The underlying documentation for all the funds listed in Exhibits 17, 18, and 19 is provided in Exhibit 20.

As noted, Exhibits 17 and 18 report fund values as of 9/30/14; they do not reflect the assets expected to be available for continued charitable use after Closing and after ECHN dissolves. ECHN contemplates that it will use fully expendable funds and appropriate net appreciation on endowment in connection with the transaction.

12. Provide copies of all correspondence, memoranda, and any other documents that include the terms of any other offers to transfer assets or operations or change control of operations received by the Hospital.

Response:

Please refer to Exhibit 5, previously referenced, for a summary of the proposals submitted. Certain proprietary information has been redacted per executed confidentiality agreements. Applicants have not provided materials protected as attorney-client work product or materials that the Applicants are not permitted to disclose under the terms of the executed confidentiality agreements.

13. Provide a copy of a fairness evaluation by an independent person who is an expert in such Asset Purchases that includes the expert's evaluation of each of the criteria set forth in Conn. Gen. Stat.§ 19a-486c(a).

Also provide copies of the information and documents relied upon by the expert in the preparation and issuance of the fairness evaluation.

Response:

A copy of the fairness evaluation performed by Duff & Phelps has already been referenced in response to Question 7.

Information provided to Duff & Phelps and relied upon in the preparation and issuance of the fairness evaluation included ECHN's audited financial statements from 2010–2013 along with projected financials for 2013-2017. The audited financial statements are already on file with OHCA. The projected financials which were prepared and provided to Duff & Phelps are included as Exhibit 21. In addition, Exhibit 22 contains a financial summary from 2010-2013 of ECHN's joint venture businesses which were included in the fairness evaluation.

14. **Describe the proposed corporate relationship between the New ECHN Hospital and the proposed VHS Waterbury Health System, LLC, including but not limited to any and all coordination of governance, control, and funding.**

    Please disclose any related strategic, market, and/or financial analyses related to Tenet's and YNHHS's contemplated ownership of VHS Waterbury Health System, LLC, and the New ECHN Hospital.

    Response:

    While a Tenet affiliate would have a controlling interest in the proposed VHS Waterbury Health System, LLC, there is no other proposed formal corporate relationship between the proposed VHS Eastern CT and VHS Waterbury Health System, LLC.

15. **Describe the proposed corporate relationship between the New ECHN Hospital and the proposed VHS Saint Mary's Health System, LLC, including but not limited to any and all coordination of governance, control, and funding.**

    Please disclose any related strategic, market, and/or financial analyses related to Tenet's contemplated ownership of VHS Saint Mary's Health System, LLC, and Tenet's and YNHHS's contemplated ownership the New ECHN Hospital.

    Response:

    While a Tenet affiliate would have a controlling interest in the proposed VHS Saint Mary's Health System, LLC, there is no other proposed formal corporate relationship between the proposed VHS Eastern CT and VHS Saint Mary's Health System, LLC.

16. Describe the proposed corporate relationship between the New ECHN Hospital and the proposed VHS Bristol Health System, LLC, including but not limited to any and all coordination of governance, control, and funding.

Please disclose any related strategic, market, and/or financial analyses related to Tenet's and YNHHS's contemplated ownership of VHS Bristol Health System, LLC, and the New ECHN Hospital.

Response:

While a Tenet affiliate would have a controlling interest in the proposed VHS Bristol Health System, LLC, there is no proposed formal corporate relationship between VHS Eastern CT and VHS Bristol Health System, LLC.

17. Please provide a copy of the transcript for the informal hearing required by Public Act 14-168, Section 9(c).

Response:

Copies of the transcripts for the informal hearings were filed on July 18, 2014 as required by Public Act 14-168 and are available on the Attorney General's website.

18. Explain how ECHN determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for the Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), respectively.

Provide discussion on history and time-line.

Response:

Please see Applicants' response to Question 5 for the time-line and discussion of how ECHN determined the need for the Asset Purchase.

The Asset Purchase will benefit MMH and RGH in numerous ways. Significantly, the transaction will provide the hospitals and ECHN's other provider organizations access to capital and resources necessary to sustain and grow high quality medical services in eastern Connecticut. In addition, the transaction will allow ECHN the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area.

The benefits of this transaction will inure to the entire ECHN community, the hospitals and its affiliates. ECHN's mission to improve the well-being of the its patients by providing high quality, compassionate care involves healthcare delivered in settings across the network continuum including care delivered at physician offices, ambulatory centers, the hospitals, its sub-acute and skilled nursing facility, Woodlake at Tolland, and in the home by Visiting Nurse and Health Services of CT. To effectively participate in the evolving risk-based payment environment, care must be managed across a complete continuum of care to deliver services in the right place at the right time. This transaction will allow ECHN the ability to rebuild and retool itself for the new world of accountable health care delivery. ECHN will be able to take advantage of Tenet's extensive resources and experience in markets across the nation where their health care systems have been successful with new risk-based payment systems and new care delivery models that reward value-based care, achieving the best outcomes for patients at lower costs. At the same time, ECHN will benefit from the clinical expertise of YNHHS. With the resources of Tenet and the clinical strength of YNHHS, not only will ECHN's hospitals see reinvestments, but ECHN will be positioned to continue developing alternative ambulatory sites of care. Development of ambulatory services, coupled with ECHN's position and participation in a larger regional network, will bring the numbers of covered lives needed to be successful in developing and executing programs to manage population health.

As a publicly traded company, Tenet has access to the capital markets that will make capital available to ECHN for: replacements and upgrades to systems and the infrastructures of our facilities; the replacement of a legacy electronic medical record to improve the documentation, the collection of information and, most importantly, the availability of information for critical treatment decisions for our patients; upgrades to the medical equipment and technology to provide our patients access to state-of-the-art technology for their diagnosis, care and treatment; and program development to attract and retain physicians to the communities served.

The transaction will bring the clinical strength and leadership of YNHHS to augment the clinical programs offered at ECHN and make opportunities available to add programs to ECHN's clinical offerings. The intent of this transaction is to develop local access to services where it is clinically appropriate. Examples of programs that can be developed at ECHN with YNHHS include a maternal fetal medicine program and teleneurology services. YNHHS would offer service line development and leadership and establish practice standards.

Being a member of the Tenet system will offer ECHN economic scale and purchasing power to reduce the cost of operations which will improve finances and ensure the sustainability of ECHN. This benefits ECHN's communities as well. The financial health of ECHN allows it to offer continued levels of employment that are critical to the health of our local economy. As important for our communities, the asset purchase will mean that ECHN will continue to offer the same levels of charity care.

With its national presence and over 80 hospitals, Tenet can offer MMH and RGH "thought leadership" to develop better models of care. ECHN staff will have access to providers across the country that have been successful at solving problems, developed best practices to overcome challenges and improved their organizations for the benefit of patients.

19. For each of MMH and RGH, provide a listing of the hospital's current service lines and service locations and describe any planned changes to both the service lines and service locations as a result of the Asset Purchase.

Provide an explanation for each change and detail how the hospital's affiliation with the Yale New Haven Health System ("YNHHS") will aid in service line development.

Response:

Services are provided on the Hospitals' main campuses as well as outpatient locations throughout ECHN's service area. Please see Exhibit 23 for the list of service lines, key services and service locations currently offered by MMH and RGH.[1]

ECHN, Tenet and YNHHS are committed to ensuring the long-term future and viability of MMH and RGH. No service line or service location changes are currently anticipated in connection with the proposed transaction. VHS Eastern CT will continue to provide care to the residents in the communities that have historically been served by ECHN.

The affiliation with YNHHS will bring the respected clinical expertise and best practices of YNHHS to MMH, RGH and the communities they serve. This will enable VHS Eastern CT to deliver existing services more effectively, enhance and expand service line offerings and potentially offer more advanced services not typically available in the community hospital setting. Using the ECHN Community Health Needs Assessment (see response to Question 25) and other planning information available to ECHN, Tenet and YNHHS will work with management to identify programs and services that best augment those currently provided in the community. In addition, YNHHS may have the ability to attract and retain certain types of specialty physicians to a community hospital setting that the hospital may not be able to attract on its own.

20. Describe the existing populations served by MMH and RGH (collectively, the "ECHN Hospitals") and how the Asset Purchase will affect these populations.

Include demographic information.

Response:

MMH, located in the town of Manchester, and RGH, located in the Rockville section of Vernon, serve patients in various towns, including Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union.

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[1] A listing of the Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) primary care and specialty care locations will be submitted in the Change of Ownership CON application for ECMPF.

The ECHN primary and secondary service areas are identified in the following map. The primary service area contains nine towns and is shaded in orange. The ten town secondary service area is shaded in yellow.

Figure 1: Eastern Connecticut Health Network Service Area



Service Area Demographics

The following table summarizes the service area population projected forward to 2020. The area population is experiencing growth in both the primary and secondary service areas. The city of Manchester is the largest municipality in the ECHN service area while Union is the smallest.

Table 2: Service Area Population

Total Population by Town 2000 - 2020

Town	2000	2011	2020
Andover	3,036	3,143	3,378
Bolton	5,017	5,006	4,882
Coventry	11,504	12,402	13,026
Ellington	12,921	15,394	18,020
Manchester	54,740	57,897	63,453
South Windsor	24,412	25,577	26,171
Tolland	13,146	14,931	16,191
Vernon	28,063	29,199	30,658
Willington	5,959	6,070	6,544
Primary Service Area Subtotal	**158,798**	**169,619**	**182,323**
Ashford	4,098	4,309	4,483
Columbia	4,971	5,449	5,787
East Hartford	49,575	51,091	53,384
East Windsor	9,818	11,024	12,543
Glastonbury	31,876	34,171	35,918
Hebron	8,610	9,620	10,188
Mansfield	20,720	26,130	27,481
Somers	10,417	11,385	10,400
Stafford	11,307	12,055	12,581
Union	693	990	958
Secondary Service Area Subtotal	**152,085**	**166,224**	**173,723**
Total Service Area	**310,883**	**335,843**	**356,046**

Source: Connecticut Economics Resource Center Town Profile November, 2013

Table 3 below displays population by service area town by age cohort. Table 4 compares age distribution by service area town to the State age distribution. The ECHN service area age distribution is consistent with that of the State of Connecticut.

Table 3: Age Distribution

Age Distribution by Service Area Town 2011

Town	0 - 4	5 - 17	18 - 24	25 - 49	50 - 64	65+	Total
Andover	192	579	150	1,040	824	358	3,143
Bolton	155	920	460	1,409	1,335	727	5,006
Coventry	473	2,342	1,061	4,464	2,743	1,319	12,402
Ellington	1,006	2,873	1,316	5,824	2,876	1,499	15,394
Manchester	4,011	8,431	5,123	21,362	11,438	7,532	57,897
South Windsor	1,270	4,940	1,955	8,333	5,528	3,551	25,577
Tolland	856	3,235	921	5,102	3,151	1,666	14,931
Vernon	1,498	3,810	2,675	10,582	5,858	4,776	29,199
Willington	218	784	1,683	1,685	1,222	478	6,070
Primary Service Area Subtotal	**9,679**	**27,914**	**15,344**	**59,801**	**34,975**	**21,906**	**169,619**
Ashford	268	663	480	1,443	1,064	391	4,309
Columbia	187	1,022	336	1,621	1,482	801	5,449
East Hartford	2,860	8,752	4,157	18,044	10,320	6,958	51,091
East Windsor	721	1,701	923	3,741	2,438	1,500	11,024
Glastonbury	1,988	7,098	1,836	11,222	7,118	4,909	34,171
Hebron	584	2,202	685	3,040	2,259	850	9,620
Mansfield	666	2,364	13,168	4,572	3,118	2,242	26,130
Somers	383	1,936	1,006	4,415	2,087	1,558	11,385
Stafford	768	1,712	1,207	4,213	2,721	1,434	12,055
Union	45	167	60	306	214	198	990
Secondary Service Area Subtotal	**8,470**	**27,617**	**23,858**	**52,617**	**32,821**	**20,841**	**166,224**
Total Service Area	**18,149**	**55,531**	**39,202**	**112,418**	**67,796**	**42,747**	**335,843**

Source: Connecticut Economics Resource Center Town Profile November, 2013

Table 4: Percent Age Distribution

Percent Age Distribution by Service Area Town 2011

Town	0 - 4	5 - 17	18 - 24	25 - 49	50 - 64	65+
Andover	6%	18%	5%	33%	26%	11%
Bolton	3%	18%	9%	28%	27%	15%
Coventry	4%	19%	9%	36%	22%	11%
Ellington	7%	19%	9%	38%	19%	10%
Manchester	7%	15%	9%	37%	20%	13%
South Windsor	5%	19%	8%	33%	22%	14%
Tolland	6%	22%	6%	34%	21%	11%
Vernon	5%	13%	9%	36%	20%	16%
Willington	4%	13%	28%	28%	20%	8%
Primary Service Area Subtotal	**6%**	**16%**	**9%**	**35%**	**21%**	**13%**
Ashford	6%	15%	11%	33%	25%	9%
Columbia	3%	19%	6%	30%	27%	15%
East Hartford	6%	17%	8%	35%	20%	14%
East Windsor	7%	15%	8%	34%	22%	14%
Glastonbury	6%	21%	5%	33%	21%	14%
Hebron	6%	23%	7%	32%	23%	9%
Mansfield	3%	9%	50%	17%	12%	9%
Somers	3%	17%	9%	39%	18%	14%
Stafford	6%	14%	10%	35%	23%	12%
Union	5%	17%	6%	31%	22%	20%
Secondary Service Area Subtotal	**5%**	**17%**	**14%**	**32%**	**20%**	**13%**
Total Service Area	**5%**	**17%**	**12%**	**33%**	**20%**	**13%**
State Total	**6%**	**17%**	**10%**	**34%**	**20%**	**14%**

Source: Connecticut Economics Resource Center Town Profile November, 2013

Table 5 below provides data regarding the socioeconomic condition of the ECHN service area towns in comparison to the State of Connecticut as a whole. With the exception of Willington (16.5%), East Hartford (16.0%), and Mansfield (17.4%), the poverty rates of towns within the ECHN service area are below the State rate of 9.5%. Median household incomes range from $49,611 in East Hartford to $107,807 in Hebron. Six of the nineteen service area towns' median household incomes are below that of the State. Three service area towns, East Hartford, East Windsor, and Stafford, had unemployment rates above that of the State.

Table 5: Socioeconomic Status of the Service Area

Socioeconomic Data

	Town	Poverty Rate[1]	Median Household Income[1]	Unemployment Rate[2]	Median Age[1]
PSA	Andover	5.7%	$91,406	6.7%	43
	Bolton	1.3%	$93,348	6.4%	45
	Coventry	3.8%	$90,502	7.9%	42
	Ellington	2.8%	$84,758	6.4%	38
	Manchester	8.2%	$62,436	8.3%	38
	South Windsor	3.7%	$92,513	6.3%	42
	Tolland	3.2%	$102,370	5.9%	40
	Vernon	8.5%	$62,115	8.1%	40
	Willington	16.5%	$67,736	6.5%	32
SSA	Ashford	5.0%	$71,346	8.1%	37
	Columbia	3.9%	$91,715	6.7%	45
	East Hartford	16.0%	$49,611	10.6%	38
	East Windsor	5.1%	$66,699	8.9%	41
	Glastonbury	3.2%	$104,967	5.5%	42
	Hebron	2.3%	$107,807	5.7%	40
	Mansfield	17.4%	$70,208	7.4%	22
	Somers	4.4%	$100,573	8.2%	42
	Stafford	6.1%	$65,570	8.6%	41
	Union	0.7%	$84,028	5.5%	43
	State	9.5%	$69,243	8.4%	40

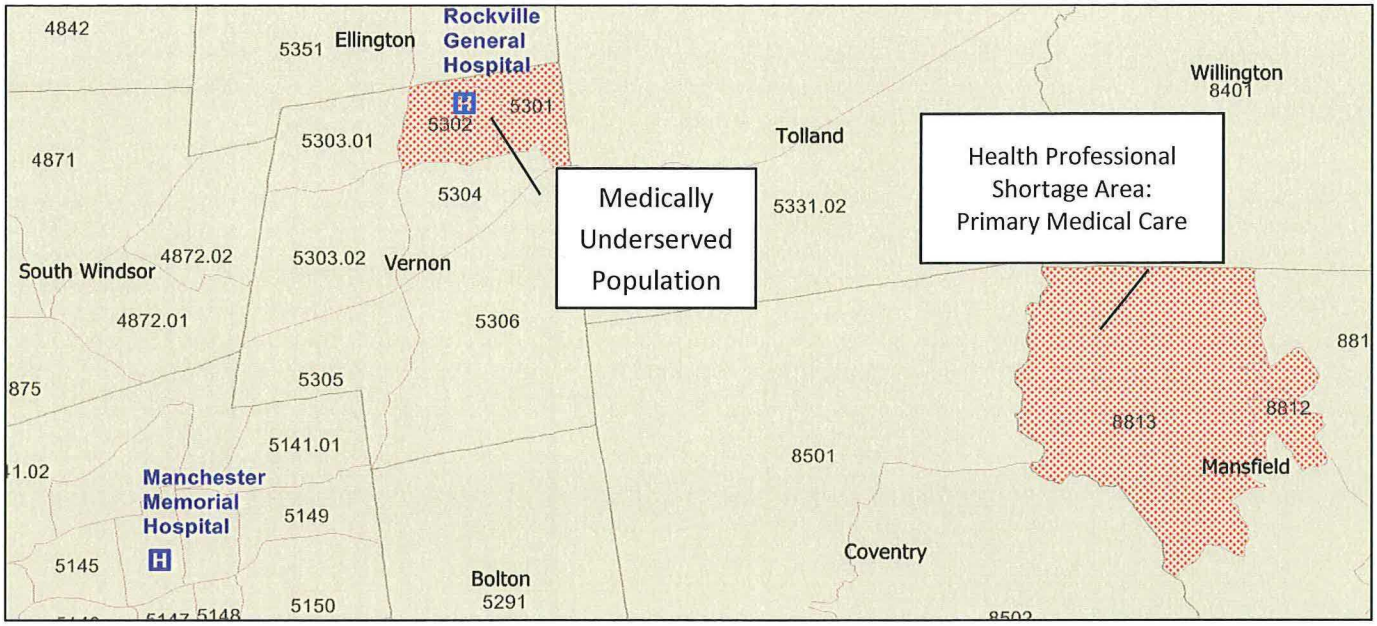
[1]2011

[2]2012

Source: Connecticut Economics Resource Center Town Profile November, 2013

The Rockville section of Vernon, where RGH is located, has been designated by the Health Resources and Services Administration as a Medically Underserved Population and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and their affiliates provide safety net services to this region of the State. This proposal will ensure that health care services will remain available to the vulnerable populations in the ECHN service area. The proposal will ensure a more secure financial future so that MMH and RGH continue to provide essential health services to the community.

Figure 2: Shortage Designation in ECHN Service Area[2]



As discussed previously in the response to Question 19, ECHN, Tenet and YNHHS are committed to ensuring the long-term future and viability of MMH and RGH. No service line or service location changes are currently anticipated in connection with the proposed transaction. VHS Eastern CT will continue to provide care to the residents in the communities that have historically been served by ECHN. Given this, the Applicants do not anticipate any changes to the populations to be served by the Hospitals.

21. How will the for-profit nature of Tenet affect the provision of health care in the community?

Response:

The provision of health care will not be affected by the for-profit nature of Tenet, as there is no correlation between tax status and the quality of care, charity care and other benefits provided to the community served. The opportunity represented by this application, however, affords the greatest opportunity for ECHN to maintain financial stability, make needed capital investments and increase the quality and access to care for the entire community.

Tenet's financial resources, access to capital and expertise in operating 80 hospitals in 14 states will positively affect the provision of healthcare in the community. Tenet's capital and access to capital will mean that VHS Eastern CT will have the financial resources to

[2] **Source:** U.S. Department of Health and Human Services, Health Resources and Services Administration

Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations (designation as of August 2014) http://www.hrsa.gov/shortage/

purchase new technology, upgrade the physical plant, attract skilled physicians, and introduce electronic health records. In addition, as the operator of 80 hospitals, Tenet will introduce practices that will reduce costs and improve care by sharing its best practices.

Tenet offers not only financial strength, but also extensive experience and expertise in operating hospitals. In order to improve the already outstanding quality of care that ECHN provides in its community, and also adapt to the new mandates of PPACA, ECHN needs to move from being an independent provider, and become part of a larger health care system. The new model of health care that is evolving from federal mandates is one which is moving from volume to value, where providers will no longer be paid strictly on the volume of patients they treat, but on the value of the health care they provide. This requires that physicians and hospitals work together, and that all caregivers in a health care system align themselves on a continuum of care with the patients' wellbeing at the center of that care. For example, if care can be appropriately provided in a clinic rather than the emergency room, it is better for most patients in terms of time and access, and it will be better for the health care system because the cost of care provided at the clinic is far less than the cost of the same care provided in a hospital emergency room.

In addition to Tenet's access to capital and its expertise in operating hospitals across the country, VHS Eastern CT and its subsidiaries will be added to state and local tax rolls and will pay taxes. Consequently, the real estate and personal property that will be owned by VHS Eastern CT and its subsidiaries will be added to the tax rolls of the communities where the property is located.

In summary, Tenet's tax status will have no negative bearing on the provision of health care in the community. Tenet's financial resources and operational expertise will, however, have a positive impact. In fact, and as evidenced in other markets where Tenet has acquired hospitals such as Detroit, MI and San Antonio, TX, the access and quality of care improved, significant capital investments were and are continuing to be made, and job growth has occurred.

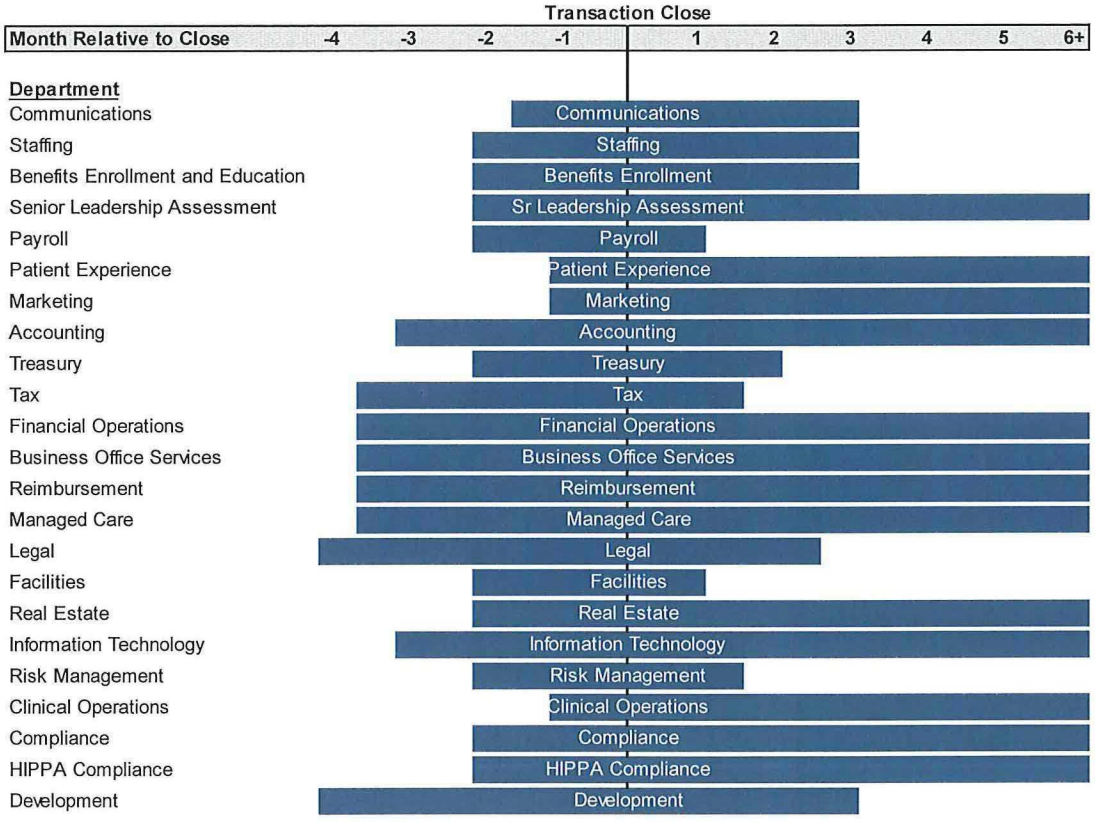
22. Provide a transition plan for the Asset Purchase and describe how ECHN, YNHHSC and Tenet (collectively, the "Applicants") will ensure continuity of care and hospital services through this plan.

Response:

The approach to the transition plan is best segregated into three phases of implementation: (1) execution of immediate cost efficiencies; (2) development of clinical efficiencies; and (3) deployment of a strategic capital plan. Immediate cost efficiencies represent benefits ECHN will receive as part of a national organization. These cost efficiencies are presented in the financial projections included in Financial Attachment 1(A) referenced later in the Application. Clinical efficiencies are captured as Tenet has the opportunity to fully engage with the medical staff and the community to jointly develop a clinical strategy to best serve the populations described in Question 20. The strategic capital plan is formulated to

complement the clinical strategy. Note that a meaningful long term integration plan requires the collaboration of the medical staff and the community. Once a needs analysis has been completed, YNHHS intends to assist VHS Eastern CT with providing the needed clinical services.

Figure 3: Sample Integration Timeline by Department



Note: The Sample Integration Timeline by Department is generic and subject to change to best meet the specific needs of VHS Eastern CT.

23. Understanding that the proposal is for VHS to exercise common ownership over MMH and RGH, how will care be coordinated between the two hospitals?

Please explain in detail how care coordination efforts will be aided by the proposed Asset Purchase (i.e., how they will be different from ECHN's present efforts), the role YNHHS will play in these efforts and provide any written plans documenting this coordinated approach to care for the patient population served.

Response:

The proposed common ownership structure will provide both Hospitals access to capital and funding necessary to provide even greater access to high quality medical services for the Manchester/Rockville region. It will provide the Hospitals assurance in their ability to execute a long range strategic plan, addressing continued improvement in quality and safety, expansion of services, new services, physician and service integration, and improvements to access to services.

Post-closing, both Hospitals will benefit from the alliance between Tenet and YNHHS. Through the alliance, YNHHS will provide to both Hospitals, through service line agreements, access to its clinical protocols, evidenced-based practices, subspecialists and clinical intellectual property. YNHHS will not be involved in the day-to-day operations of either Hospital, nor will YNHHS have any involvement in the management of either Hospital.

24. Provide a description of the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

Response:

The APA is consistent with the Statewide Health Care Facilities and Services Plan (the "Plan") published by the Connecticut Department of Public Health's Office of Health Care Access ("OHCA") in October of 2012. The Plan can be found on OHCA's website. The transaction contemplated by the APA is clearly aligned with the premise of the Plan. Section 1.4 of the Guiding Principles of the Plan states:

The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.

The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;
- Ensure that any regulated service will maintain overall access to quality health care;
- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;
- Encourage collaboration among health care providers to develop health care delivery networks;

- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);

- Maintain and improve the quality of health care services offered to the state's residents;

- Promote planning that helps to contain the cost of delivering health care services to its residents;

- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;

- Promote public policy development through measuring and monitoring unmet need; and

- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state. (Plan at p. 2).

As the Plan makes clear, as of 2012, OHCA was aware that mergers, affiliations and acquisitions were part of a transformation that had begun as the State's health care system responded to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5). Becoming part of a larger corporate health care system such as Tenet will aid ECHN and its provider affiliates in developing economies of scale when purchasing supplies and services, and will also improve access to capital. These factors, in turn will allow ECHN and its provider affiliates to improve the quality of care that is required by PPACA.

As OHCA has recognized in the Plan, the strategic financial and quality of care advantages associated with the affiliation or mergers of hospitals and health care providers is a key driver in today's health care environment. Connecticut hospitals are pursing affiliation arrangements and mergers as a means of offsetting financial pressures due to the provision of uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients and reduced reimbursement by the government payers and health insurers. Hospitals are struggling to make needed facility improvements and acquire needed technology. (Plan at pp. 7-8, Sec. 1.8.5 and pp. 11-12, Sec. 2.1.1). This proposal serves as an example of this trend. The implementation of the proposal will allow ECHN and its provider affiliates to meet their financial obligations, make needed capital improvements, acquire new technology and continue to provide the same level of services currently available in the surrounding communities.

By entering into the proposed APA, ECHN and its provider affiliates will be able to fulfill ECHN's obligations, including retiring its debt, and funding its pension plan. As a result, VHS Eastern CT will be better positioned to expand cost control initiatives in community-based settings, and remain a lower-cost, high-quality provider for the patients in its service area.

As part of the Tenet system, VHS Eastern CT and its provider affiliates will be able to improve their technology and the overall standard of care for its patients. The Plan

recognizes that a health information technology exchange ("HITE") "makes it possible for health care providers to better manage patient care through secure use and sharing of health information." (Plan at p. 14, Sec. 2.2.1). As a part of the strategic planning process, Tenet will consider funding the cost of replacing ECHN's legacy electronic medical records system with an enterprise-wide system to further develop electronic health records ("EHRs") which will offer more accessible, accurate, timely and comprehensive patient information to treat patients across patient care settings. Opportunities to further integrate care delivery among ECHN providers and regionalize the health care delivery system in the ECHN service area will be enhanced, to more effectively identify patients at risk and build upon existing initiatives such as ECHN's telemedicine program which monitors patients with chronic conditions such as with congestive heart failure in their homes. The scope of the Tenet system will provide VHS Eastern CT with regional and national scale resources to meet the health care reform requirements of the PPACA.

The PPACA requires hospitals to improve quality of care delivered to patients through a variety of means such as improving infection control programs and reducing preventable readmissions for certain conditions. (Plan at pp. 12-13, Sec. 2.1.2, 2.1.3, 2.1.4., 2.1.4.2 and 2.1.4.3). Tenet, as a national hospital chain, is aware of these requirements and has the ability to share best practices among its member hospitals, potentially improving infection control programs and reducing readmissions. This proposal promotes Population Health Management which is a system that emphasizes health promotion and the delivery of preventive and medically necessary care. Population Health Management promotes collaboration among providers and the development of a continuum of care where providers are more closely aligned and work in a cohesive environment. The collaboration with Tenet and its experience with 80 hospitals will provide an environment that aligns VHS Eastern CT's physicians and other providers across the continuum of care, provide access to evidence-based practices to improve quality and patient safety, enhance efficiency through uniform productivity and financial management, and develop integrated information systems.

25. Reference is made to the MMH and RGH Community Health Needs Assessment Final Report 2013 and the priority health needs of heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence identified therein. Please explain how the new joint venture entity, VHS Eastern Connecticut Health System, LLC ("VHS") will address the needs of service area residents with respect to prevention and treatment of these diseases and conditions.

Response:

In 2013, MMH and RGH collaborated to conduct a comprehensive Community Health Needs Assessment (CHNA).

The goals of the assessment were to identify the current and future healthcare needs of the community and to improve and strengthen the programs and services available to address them.

The CHNA process was led by an Oversight Committee that included individuals from ECHN with established relationships with community groups and agencies. Data was collected from community, civic and social service agencies, as well as residents and community leaders to describe the demographics, morbidity and mortality statistics and health indicators. Once assembled, the data was analyzed and reviewed by the Oversight Committee, who then identified and prioritized the service area's key health needs.

Four priority health needs were identified by the Oversight Committee related to heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. An implementation plan to respond to the identified health needs was developed with an overall goal to (1) reduce preventable risk factors that contribute to incidence of the respective health issue and (2) promote quality of life for those diagnosed. The implementation plan identified specific strategies and tactics to be employed in order to attain this goal.

The CHNA and the implementation plan were reviewed and approved by the ECHN Strategic Planning Committee on August 21, 2013. The ECHN Board of Trustees reviewed and approved the CHNA and implementation plan on September 25, 2013. Please see Exhibit 24 for a copy of the Community Health Needs Assessment Implementation Plans for MMH and RGH.

ECHN, Tenet and YNHHS are committed to improving the overall health of the communities served by MMH and RGH. VHS Eastern CT and its affiliates will continue to support the CHNA implementation plans which will continue to be rolled out through 2016. The current implementation strategy initiatives identified in the plan include:

Strategies to Address Heart Disease Incidence:

- Educate the public about managing lifestyle behaviors that impact diet, blood pressure, cholesterol, weight, physical activity, and stress.
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area where free blood pressure, cholesterol, body fat composition analysis and educational resources will be shared.
  - Launch the "Freedom from Smoking" smoking cessation program.
  - Provide nutrition counseling services.
  - Offer integrative medicine programs for stress reduction.
  - Provide information and services to individuals diagnosed with heart disease to help them best manage their symptoms.
  - Offer free "Heart Talk" community program for people living with heart failure.

- Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level.

Strategies to Address Cancer Incidence:

- Monitor reports of newly-diagnosed cancer cases in the service area using the National Cancer Center Data Base (NCDB) to identify significant changes, trends or abnormal activity.

- Educate the public about managing lifestyle behaviors that impact cancer risks

  - Cancer Community Outreach Community will coordinate free community health educational lecture and seminar programs.
  - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.
  - Launch the "Freedom from Smoking" smoking cessation program.

- Provide free screenings in the community and access to follow-up care.

- Offer comprehensive support programs for cancer survivors and caregivers.

  - Oncology Nurse Navigator and Survivorship Navigators services
  - Annual Cancer Survivors Day event
  - Regular support group meetings
  - Cancer Caregiver Workshops

Strategies to Address Diabetes Incidence:

- Raise awareness of diabetes preventable risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity.

  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared.

- Offer Diabetes Self-Management Program and Nutrition Counseling for individuals already diagnosed with diabetes.

Strategies to Address Arthritis Incidence:

- Educate the public about ways to help prevent or slow the progression of arthritis and manage the symptoms of joint pain.
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.

- Offer free program to help individuals with arthritis prepare for hip or knee replacement surgery and achieve the best outcome.

- Develop a comprehensive surgical spine program to support individuals experiencing chronic neck and back pain including symptom management and perioperative care.

VHS Eastern CT, its affiliates and Tenet will provide financial support to continue implementing these initiatives. Section 5.16(b) of the proposed Asset Purchase Agreement states that the "Buyer [VHS Eastern CT] will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and to improve the health status of the elderly, poor, and at-risk populations in the community." Additionally, VHS Eastern CT will conduct a follow-up CHNA in 2016 and develop a new implementation plan to address identified needs in the local community.

Until such time as a new implementation plan has been developed, VHS Eastern CT will continue to focus efforts on reducing the incidence of heart disease, cancer, diabetes and arthritis in the surrounding communities. VHS Eastern CT will look to other Tenet hospitals and YNHHS to enhance the efforts previously identified by MMH and RGH in their original plan, and incorporate best-practice recommendations for disease prevention, early detection screenings, and treatment options within each of the priority areas.

<u>Support from Tenet in implementing strategies to address priority needs:</u>

Tenet has demonstrated nationwide its ability to address many of the same priority needs identified in the MMH and RGH Implementation Plan. Several Tenet hospitals adhere to the Get with the Guidelines Heart Failure Program, a collaborative quality improvement initiative administered by the American Heart Association with a focus on enhancing patient outcomes and saving lives. MMH and RGH have recently attained participation status in the Get with the Guidelines Heart Failure Program and, once they are part of the Tenet network, will be able to reach out to other participating Tenet hospitals for guidance and support in achieving the Gold Plus status designation. Additionally, Tenet offers cardiac rehab services at twenty-seven of its hospitals, and

will continue to support the current service offerings provided at MMH and RGH following the asset purchase.

Tenet operates twenty-four comprehensive Cancer Centers throughout the United States. These centers are designed to deliver a broad range of oncology services while also providing the support services necessary to coordinate care and meet community needs including, but not limited to, nutritional counseling, support groups, palliative care and patient education related to symptom recognition, screening and early diagnosis through health fairs and targeted community outreach activities. Tenet is committed to educating the communities it serves about cancer prevention and awareness. At Tenet's Baptist Health System in San Antonio, Texas, for example, the hospitals offer regular "lunch and learn" programs which are free to the public and provide education on topics such as breast health from one of their comprehensive cancer center nurse navigators. As Tenet hospitals, MMH and RGH will continue to offer similar programs focused on cancer prevention and early detection to the local community.

Tenet's commitment to addressing the health concerns of the communities served related to chronic disease, including obesity and diabetes, is illustrated by the development of Baptist Health System's Family Health Clinic (San Antonio, Texas) which was created in partnership with other community entities to address chronic conditions affecting underserved populations. Additionally, Tenet hospitals nationwide frequently provide educational opportunities to help patients better understand and manage chronic diseases. For example, Sierra-Providence Health Network offered a dozen chronic disease management seminars in 2013.

Spine centers developed at several Tenet facilities were created to improve outcomes for patients with back and neck pain, using best-practice conservative treatment options before pursuing more invasive surgical options. Care at these facilities is provided with a high-level of patient involvement, which is encouraged through patient education and the use of web-based tools that provide comprehensive resources on exercise, symptom management, injury prevention, ergonomics, non-surgical and surgical treatment options. For example, Hahnemann University Hospital in Philadelphia offers a comprehensive spine center with a range of treatment options, starting with the least invasive treatment options first. The Hahnemann spine center offers special programs to the various community groups focused on prevention including back injury prevention and "Healthy Back" programs. ECHN's spine program will have the opportunity to enhance and expand its program offerings consistent with other Tenet hospitals.

The evaluation of efforts to address community need in the areas of heart disease, cancer, diabetes and arthritis undertaken by other Tenet hospitals and the implementation of similar care delivery models to address these concerns, where applicable, will help VHS Eastern CT to implement more effective strategies that better address the priority community needs.

Support from YNHHS in implementing strategies to address priority needs:

Within their local community, YNHHS offers comprehensive services across the care continuum that address some of the same priority issues identified in the MMH and RGH Implementation Plan. With guidance from experts at YNHHS, VHS Eastern CT can use the various YNHHS care delivery models to enhance or augment the strategies developed for the ECHN Implementation Plan, where applicable, and better address the community needs identified in eastern Connecticut.

For example, YNHHS' Heart and Vascular Center at Yale-New Haven Hospital (YNHH) offers a wide range of preventative and acute cardiac services, including a variety of outreach and education programs to support cardiac patients and families and to help raise awareness in the community about the risks and signs of heart disease. Their Women's Heart Program is dedicated to helping women assess their heart attack risk and recognize its signs and symptoms.

The Smilow Cancer Hospital at Yale-New Haven offers the latest in cancer screening, diagnosis and treatment options and offers breast, cervical and colonoscopy screening for uninsured and underinsured men and women. YNHH's participation in national and statewide programs, such as Connecticut Breast and Cervical Cancer Early Detection Screening Programs (CBCCEDP), Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), and Komen for the Cure Connecticut's Strategic Alliance Learning for Outreach and Patient Navigation (SALON) program, has helped to provide education and screening services to increase awareness of cancer early detection for high-risk populations.

YNHH's Diabetes Center is a regional resource for diabetes diagnosis, education and diabetes treatment. The Diabetes Center, which is an American Diabetes Association-recognized site for diabetes education, offers free educational diabetes program for patients and their families and focuses on lifestyle interventions, along with the latest medications and technologies, to treat or prevent diabetes.

Members of the VHS Eastern CT community health implementation team (Oversight Committee) will have the opportunity to connect with experts at YNHHS facilities for the development of similar community outreach efforts that support awareness and prevention of heart disease, cancer, diabetes and arthritis. Opportunities for more formal relationships with the YNHHS service lines will be explored and implemented as necessary to bring more comprehensive tertiary services and support VHS Eastern CT's development of community-based programs for prevention and early detection in the local community.

26. Provide a description of plans that VHS will implement to control cost, such as discharge care coordination, implementation of electronic medical records and emergency department triaging to the appropriate level of care.

In responding to this question, report any anticipated savings from the following expense categories for the ECHN hospitals: salaries and wages, fringe benefits, contractual labor fees, medical supplies and. pharmaceutical costs, depreciation and amortization, bad debts, interest expense, malpractice expense, utilities, business expense and other operating expenses.

Response:

Although the Hospitals' costs are competitive as shown in Exhibit 25, VHS Eastern CT will continuously seek opportunities to reduce costs and improve efficiency. The specific anticipated savings are presented by expense category in response to Question 39 and described in response to Question 40.

Tenet is implementing cost control programs as it establishes the framework to accelerate the journey from fee-for-service to fee-for-value. Leading health systems are best positioned to transform the health care system in partnership with the communities they serve. Tenet believes that it must establish comprehensive health care delivery systems if it is to remain competitive in each of its markets. To this end, Tenet is engaging rapidly on the following initiatives:

- ***Enhanced Physician Alignment***
  - Tenet's overarching strategy is to achieve clinical integration with its physician partners. This can be achieved in a number of ways including employment and professional service agreements and integrated care models with independent practicing physicians. This approach also includes identifying and serving the clinical needs of the communities where Tenet is located. Tenet has nearly 36,000 affiliated physicians (2,000 of these physicians are employed by Tenet) in 14 states. Tenet's dedicated Physician Resources segment is described in more detail below.

- ***Population Health Management Infrastructure and Capabilities***
  - Conifer Health Solutions, a Tenet subsidiary, offers a Population Health Management platform that offers care teams secure web-based access to the comprehensive clinical and financial information needed to manage a given population's health. This platform integrates disparate data and provides users easy access to disease registries, gaps-in-care, predictive analytics, population-risk stratification, hospital admission data, and referral data. Currently, Healthspan (an Ohio based provider), Quality Care Partners, and Unity Point (formerly Iowa Health System) are fully utilizing Conifer's Population Health Management platforms, as describe below:
    - A Dashboard application that provides a quick overview of the managed population and links to all other applications
    - A Risk-Stratification application that segments the population into five levels of risk and presents the underlying triggers associated with each risk level

- A Population's Conditions application that takes the guesswork out of identifying those patients who have gaps in compliance; thus, improving care and reducing costs by providing the care team with a list of patients needing care
- A Participant Portal application that provides 24/7 access to tools that help participants more effectively self-manage their health
- A Medical Management application that facilitates care coordination, communication, and connection with the at-risk population

- ***Ambulatory Care Services Development***
  - Tenet's robust outpatient care strategy is designed to increase access points in a lower cost, convenient setting. Tenet's Outpatient Services Division currently operates approximately 200 outpatient centers that include, ambulatory surgery centers, diagnostic imaging centers, urgent care centers and free standing emergency departments. These outpatient centers provide options for patients to receive care in convenient and lower cost locations separate from the hospital campus. A new and key component of Tenet's outpatient strategy is the MedPost Urgent Care network launched in May 2014. Tenet's urgent care footprint has grown from 15 centers in 2013, with plans to add 40-45 additional centers by year-end 2015.

- ***Post-acute Care Development***
  - Tenet Home Health & Post-Acute Services expands the Outpatient Services Division and rounds out Tenet's integrated care delivery network by collaborating with Tenet's acute care hospitals and the Tenet Physician Resources (TPR) segment (described below).

    Each day Tenet cares for 2,000 patients in their homes through a variety of programs including home care, hospice and private care. In addition, Tenet provides care to thousands of patients each year through Tenet's Transitions in Care Programs, which encompass Transition Care Coaches, Coleman Coaches and post discharge telephonic care. These programs assist Tenet hospitals, ACOs and Bundled Payment Care Initiatives (BPCI) in population health management and reducing readmissions. Tenet's vision includes embracing innovative approaches to care delivery to assist patients to better self-manage their health and to remain in their homes.

    Tenet also operates 17 inpatient rehabilitation units. Most of these units are part of a larger, acute care hospital. The exception is the Rehabilitation Institute of Michigan (RIM), a 94-bed freestanding rehabilitation hospital in Detroit. RIM is one of only three freestanding rehabilitation hospitals in the country, recognized with Magnet status by the American Nurses Credentialing Center. Magnet recognition is awarded only to hospitals that exceed professional standards in nursing practice, leadership, education and

research. Four of Tenet's units, including RIM, are accredited by the Council on Accreditation of Rehabilitation Facilities (CARF).

Additionally, several Tenet regions have begun quality initiatives that involve collaborating with post-acute care providers to improve care transitions and communicate more effectively, in an effort to reduce readmissions.

- ***Primary Care Development***
  - Tenet understands the need for comprehensive population health. To meet this demand, Tenet has been redesigning its care delivery (in particular, primary care) to align with the Institute of Medicine's ("IOM") six dimensions of quality care: safe, effective, patient-centered, timely, efficient and equitable, through building a highly reliable organization.

    Tenet's inaugural national primary care advisory commences in November 2014. The primary care advisory is comprised of active physicians currently engaged in patient care in Tenet's markets across the nation. The primary care advisory's focus is to ensure the Tenet Physician Resources segment follows the six IOM pillars for success with patient and employee safety as the cornerstone of care.

    Tenet Physician Resources (TPR) is responsible for physician alignment, management of physician practices and physician recruitment. TPR's alignment strategies include, but are not limited to, acquiring physician practices, contracting with physicians through employment contracts and professional services agreements and recruiting needed physicians to the communities that Tenet serves.

    In addition to Tenet's Physician Resources Department's responsibilities described above, it is increasing access and availability for patients through expanded clinical hours, urgent care partnerships and alternative methods of patient encounters utilizing the latest in smart phone technology.

    Tenet's Physician Resources Department also has the experience and skillset to achieve the Triple Aim of population care and is moving past descriptive analytics to predictive analytics to prevent unnecessary morbidity and mortality.

Each of the aforementioned efforts is geared towards providing the right care at the right time, and in the most appropriate setting, with the ultimate goal of providing the highest quality of care at the most economical cost.

27. Provide a description of VHS' plans to continue to provide services to the uninsured and underinsured.

In responding to this question, please describe any changes to the ECHN Hospitals' current charity care, uncompensated care and financial assistance policies and procedures, and hospital bed funds that will result from the Asset Purchase.

Describe any plans VHS has to work with other providers in the community, such as federally qualified health centers or community health centers, to provide specialty care to patients, or low cost programs that VHS will provide in the area that are tailored towards the uninsured or underinsured.

Response:

VHS Eastern CT will continue to provide exceptional care and the same if not better level of services as ECHN currently provides to the uninsured and underinsured. VHS Eastern CT will adopt the existing ECHN charity care policies. There are currently no plans for VHS Eastern CT to work with other providers in the community such as federally qualified health centers or community health centers to provide specialty care to patients, and no specific plans for VHS Eastern CT to implement separate programs tailored towards the uninsured or underinsured. Existing charity policies that will remain in effect will support the continued provision of services to these patient populations. VHS Eastern CT will continue to operate low cost hospitals and provide great value to those in need.

28. Submit a list of all key professional, administrative and clinical department heads related to this proposal. Additionally, provide a copy of the Curriculum Vitae of each individual listed.

Response:

Eastern Connecticut Health Network

ECHN's Administrative and Clinical Department Heads include the following. Curriculum Vitae for each are included as Exhibit 26.

Peter Karl, President and Chief Executive Officer
Deborah Gogliettino, Sr. VP of Human Resources and Chief Human Resources Officer
Dennis McConville, Sr. VP and Chief Strategy Officer
Deborah Parker, Executive Vice President and Chief Clinical Officer
Mary Powers, Sr. VP Patient Care Services
Joel Reich, MD, Sr. VP of Medical Affairs and Chief Medical Officer
Joyce Tichy, Sr. VP and General Counsel
Michael Veillette, Sr. VP of Finance and Chief Financial Officer
Gregory Williams, Sr. VP Network Services
Pamela Lewis, MD, President, ECHN Medical Staff

Maher Suede, MD, Vice President, ECHN Medical Staff

Tenet

Tenet Administrative and Clinical Department Heads include the following. Curriculum Vitae for each are included as Exhibit 27.

Harold "Trip" Pilgrim, Senior Vice President, Development
Erik Wexler, Chief Executive Officer, Northeast Market
Kelvin Baggett, M.D., Chief Clinical Officer and Senior Vice President of Clinical Operations
Mark Montoney, M.D., Chief Medical Officer

Yale-New Haven Health System

Please note that YNHHS will not be in a managerial or operational position. YNHHS Administrative and Clinical Department Heads include the following. Curriculum Vitae for each are included as Exhibit 28.

Gayle L. Capozzalo, Executive VP and Chief Strategy Officer, YNHHS
Richard D'Aquila, Executive VP, YNHHS and President, Yale-New Haven Hospital
Christopher O'Connor, Executive VP and Chief Operating Officer, YNHHS

29. Provide evidence as to how the Asset Purchase will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to:

a. Provision of or any change in the access to services for Medicaid recipients and indigent persons; and

b. The impact upon the cost effectiveness of providing access to services provided under the Medicaid program.

Response:

a. Medicaid recipients and indigent persons will have the same, if not better, access to high quality services than that to which they currently have access. One expected component of the capital expenditures that Tenet will make is to add ambulatory access points in the region, thus providing increased access for the broader community, including Medicaid recipients.

The proposed transaction also will improve the quality of health care delivery in the region because the Hospitals will have access to Tenet's quality and patient safety programs. The 80 hospitals owned by Tenet, through a structure comprised of 'Clinical Care Councils' (see below), regularly share best practices, focusing on clinical areas that include perioperative, obstetrics, critical care, emergency departments, etc. Additionally, coordinated initiatives targeting discharge planning, care management, service line planning and emergency preparedness also will benefit the Hospitals. VHS

Eastern CT will learn from peer hospitals and improve the quality of care in the region by implementing proven best practices driven by the experience of 80 hospitals.

As stated above, VHS Eastern CT will benefit from best practices and Tenet's evidence-based approach to clinical quality through participation in Tenet's Clinical Councils, which are representative groups of physicians, nurses and other clinical staff in specific disciplines. The Clinical Care Councils are designed to provide insight, perspectives and expertise that shape practice to drive clinical variability out of the system and make care more consistent with the best available evidence and clinical standards. The Clinical Care Councils also serve as a consistent and readily available avenue for Tenet leaders to access clinical insights.

In addition to the continued access to quality care, residents of the region will have access to education on coverage options and assistance in enrolling in coverage. In conjunction with the introduction of insurance exchanges and the expansion of Medicaid, Tenet launched an education and enrollment initiative called Path to Health to inform newly eligible individuals about their coverage options under the PPACA. This campaign is a joint effort among Tenet hospitals, Conifer Health Solutions and more than 350 community-based partner organizations. Since the start of the campaign, local hospitals and Tenet's partners have held more than 460 enrollment and educational events, produced more than 1 million pieces of educational material, sent direct mail pieces to nearly 250,000 households and provided enrollment assistance to nearly 13,000 consumers.

b. The proposed transaction will improve cost effectiveness of health care delivery in the region. Tenet implements various operational strategies that improve efficiency and reduce costs of care. Tenet's Home Office Performance Management and Innovation (PMI) department provides the following functions designed to maximize efficiency:

Throughput

- Excess Day reviews and implementation of "TEMPO": Team Engagement To Manage Patient Outcomes
- Discharge by 12:00 noon reviews and analysis of areas for improvement
- Appropriate utilization of ICU versus Medical/Surgical beds
- ER length of stay improvement
- ER left without being seen reduction
- Surgery Case on time starts
- Surgery Start average delay reduction
- Surgery case turnaround time improvement
- Reduction of OR Cancellations
- Right product/right time reviews for OR supplies, reducing or eliminating product waste
- LEAN Daily Management implemented in other Tenet hospitals has resulted in an average of $431,000 of savings within the first year of utilization, through

employee engagement and identification of areas that require operational improvement
- Full LEAN engagement (ER/Inpatient/OR) implemented in other Tenet hospitals has generated savings opportunities that range between $2.1M and $4.6M per year in process driven efficiency

Labor

- Education of leaders in how to complete and implement staffing grids to drive efficiency and reduce overtime and utilization of costly contract labor while maintaining quality metrics
- Guidance on implementation of "Top of License" to ensure that nurses are performing tasks that fully utilize their licensed capabilities (i.e., working at the "top of their license") and not spending valuable nursing time on tasks that can and should be performed by others who are less skilled
- Labor/productivity targets by department based upon individual unit and volume to ensure efficient staffing while achieving quality goals
- Guidance on proper utilization of full time to part time in order to pool employees to eliminate unnecessary over time and "call offs" (a secondary benefit of this is a reduction in turn-over, which is very costly)

Supply and Sourcing Costs

- Medication Utilization Management programs for both conversions to generic, conversions from IV to PO and product conversions
- Physician Preference Item scaling based upon tiers of volume from larger system perspective (leverage)
- Food and Nutrition Services Review: external contracting with leveraging of value, standardized regional menus, staffing appropriateness, reduction in waste meals
- Clinical Contracting: leveraging of scale and removal of fee for service contracting to align with facility payments (DRG/CASE, etc.)
- Document Management programs to assess utilization of printers and copiers by type, load, and utilization of color printing
- Security Contracting: national service level agreements, reviews of technology versus manpower
- Reprocessing programs

30. Provide the corporate organizational chart prior to and after the proposed Asset Purchase, including all affiliates.

For the organizational chart that depicts the post-Asset Purchase structure, working upward on the chain of ownership from VHS, the entity that will own and operate the two hospitals, please:

(i) **Describe the nature of the ownership and control that each entity has in the entity directly below it;**

(ii) **Describe the major business activities/functions of each entity;**

(iii) **Provide the principal place of business address for each entity; and**

(iv) **Provide the name and business address of each individual currently serving as a member of the governing body of each entity.**

Response:

The following is a description of the post-Asset Purchase entities that will own and operate VHS Eastern CT and its affiliates:

As referenced above, Tenet is an investor-owned company whose subsidiaries and affiliates operate regionally focused, integrated health care delivery networks with a significant presence in several large urban and suburban markets. As of June 26, 2014, Tenet, through its various subsidiaries, operated 80 hospitals and 200 outpatient centers. Tenet's principal place of business is 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. The following individuals currently serve as directors of Tenet: (i) Edward A. Kangas; (ii) John E. (Jeb) Bush; (iii) Trevor Fetter; (iv) Brenda J. Gaines; (v) Karen M. Garrison; (vi) J. Robert (Bob) Kerrey; (vii) Richard R. Pettingill; (viii) Ronald A. Rittenmeyer; and (ix) James A. Unruh.

Vanguard Health Systems, Inc. is a holding company that was previously the ultimate parent company of the Vanguard entities. Vanguard Health Systems, Inc. was acquired by Tenet on October 1, 2013. Vanguard Health Systems, Inc. does not currently have any other material independent operations or assets other than holding the membership interests in Vanguard Health Holding Company I, LLC and other Tenet subsidiaries, directly or indirectly. Vanguard Health Systems, Inc.'s principal place of business is 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. The following individuals serve as directors of Vanguard Health Systems, Inc.: (i) Jeffrey Peterson; and (ii) Paul Castanon.

Vanguard Health Holding Company I, LLC is a holding company that holds the outstanding equity interests in Vanguard Health Holding Company II, LLC. Vanguard Health Holding Company I, LLC does not currently have any other material independent operations or assets other than holding the membership interests in Vanguard Health Holding Company II, LLC and other Tenet subsidiaries, directly or indirectly. Vanguard Health Holding Company I, LLC's principal place of business is 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. The following individuals serve as managers of Vanguard Health Holding Company I, LLC: (i) Jeffrey Peterson; and (ii) Paul Castanon.

Vanguard Health Holding Company II, LLC is a holding company that holds the outstanding equity interests in Vanguard Health Management, Inc. Vanguard Health Holding Company II, LLC does not currently have any other material independent operations or assets other than holding the equity interests in Vanguard Management, Inc. and other Tenet subsidiaries, directly or indirectly. Vanguard Health Holding Company II, LLC's principal

place of business is 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. Vanguard Health Holding Company II, LLC is member managed by its sole member, Vanguard Health Holding Company I, LLC. The following individuals serve as managers of Vanguard Health Holding Company II, LLC: (i) Jeffrey Peterson; and (ii) Paul Castanon.

Vanguard Health Management, Inc. is a holding company that holds the outstanding equity interests in Vanguard Health Financial Company, LLC. Vanguard Health Management, Inc. is the primary employer of personnel at Tenet's corporate offices in Nashville, TN. Otherwise, this entity does not currently have any other material independent operations or assets other than holding the membership interests in Vanguard Health Financial Company, LLC and other Tenet subsidiaries, directly or indirectly. Vanguard Health Management, Inc.'s principal place of business is 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. The following individuals serve as directors of Vanguard Health Management, Inc.: (i) Jeffrey Peterson; and (ii) Paul Castanon.

Vanguard Health Financial Company, LLC is a holding company that will hold the outstanding equity interests in the to-be formed company referenced as VHS of Connecticut, LLC in the Organizational Chart. Vanguard Health Financial Company, LLC provides intercompany lending to certain Tenet subsidiaries. Otherwise, this entity does not currently have any material independent operations or assets. Vanguard Health Financial Company, LLC's principal business address is 1445 Ross Avenue, Suite 1400, Dallas, Texas 75202. Vanguard Health Financial Company, LLC is member managed by its sole member, Vanguard Health Management, Inc. The following individuals serve as directors of Vanguard Health Financial Company, LLC: (i) Jeffrey Peterson; and (ii) Paul Castanon.

VHS of Connecticut, LLC has not yet been formed but it is anticipated that it will serve as a holding company for other entities that will own and operate hospital-related assets within the State of Connecticut. This entity will not own or operate any hospitals or hospital-related assets directly or have any other business operations other than to act as the holding company for the interests in each of the hospital or hospital system subsidiaries. VHS of Connecticut, LLC will have 80% of the membership interests in the to-be formed Regional Provider with YNHHS holding the remaining membership interests.

YNHHS is a Connecticut non-stock corporation that is the parent company of Yale-New Haven Hospital, Inc., Bridgeport Hospital, Greenwich Health Care Services, Inc., Northeast Medical Group, Inc. and other affiliated providers. YNHHS will hold 20% of the membership interests in the to-be formed company referenced as Regional Provider. YNHHS's principal business address is 789 Howard Avenue, New Haven, Connecticut 06519. The following individuals currently serve as directors of Yale-New Haven Health Services Corporation: (i) Marna P. Borgstrom; (ii) Joseph R. Crespo; (iii) Neil P. DeFeo; (iv) Mary C. Farrell; (v) Thomas B. Ketchum; (vi) John L. Lahey; (vii) Marvin K. Lender; (viii) Julia M. McNamara; (ix) Daniel J. Miglio; (x) Barbara B. Miller; (xi) Daniel L. Mosley; (xii) Ronald B. Noren; (xiii) Benjamin Polak; (xiv) Meredith Reubin; (xv) Peter Salovey; (xvi) Elliot J. Sussman, M.D.; and (xvii) James Torgerson.

Regional Provider, the to-be formed joint venture between VHS of Connecticut, LLC and YNHHS, will serve as the holding company for the subsidiary business entities that will be

established for the purpose of purchasing, owning and operating one or more healthcare facilities or providers. VHS of Connecticut LLC will hold 80% of the membership interests and YNHHS will hold the remaining 20% of the membership interests in the Regional Provider LLC. The Regional Provider LLC will hold 100% of membership interest in the to-be formed company VHS Eastern CT.

VHS Eastern CT has not yet been formed but it is anticipated that it will serve as the subsidiary company that will own and operate the ECHN hospitals and other ECHN system-affiliated entities to be acquired from ECHN.

Other Related Entities

Tenet Medical Foundation, Inc.[3] has not yet been formed but it is anticipated that it will employ physicians and healthcare care providers from each of the health systems being acquired. This entity will acquire the assets and assume the liabilities of Eastern Connecticut Medical Professionals Foundation, Inc. VHS of Connecticut, LLC will have 100% of the membership interests in the Tenet Medical Foundation, Inc.

The Risk Organization LLC is a separate joint venture to be formed between VHS of Connecticut, LLC and YNHHS. VHS of Connecticut, LLC and YNHHS will each have 50% membership interest in the Risk Organization, LLC. The VHS Eastern CT affiliate VHS Clinically Integrated Network of Eastern Connecticut, LLC will have a contractual arrangement with the Risk Organization LLC, who will negotiate and enter into risk-sharing agreements with Medicare, Medicaid and other third party payers on behalf of VHS Clinically Integrated Network of Eastern Connecticut, LLC. The Risk Organization LLC will have no ownership interests in any of the ECHN assets to be acquired through this proposed transaction.

Please see Exhibit 29 for ECHN's organizational chart prior to the Asset Purchase.

Please see Exhibit 30 for VHS Eastern CT's organizational chart after the Asset Purchase.

31. Please provide the date on which each of MMH and RGH filed audited financial statements with OHCA. Applicants may reference these statements in responding to questions.

Response:

MMH and RGH filed FY 2013 audited financial statements with OHCA on February 27, 2014.

[3] The Tenet Medical Foundation, Inc. was previously referred to as the Regional Physician Network Organization in the Greater Waterbury Health Network application (Docket Number 13-486-01 and 13-31838-CON) and the Saint Mary's Health System application (Docket Number 14-486-02 and 14-31927-486).

32. List all funding or financing sources for the $105,000,000 Asset Purchase (the "Purchase Price") by VHS and VHS' commitment to invest $75,000,000 in facility improvements, general upgrades and renovations, deferred maintenance, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff (the "Capital Commitment").

Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Response:

Tenet will use cash to pay the Purchase Price. Cash also will be used for the $75,000,000 in capital expenditures. Details such as interest rate, term, and monthly payment amounts do not apply to this Asset Purchase.

33. Please explain in detail the reasons why, and with respect to each item, the extent to which, the Purchase Price for ECHN's assets may be adjusted for each of the following:

a. outstanding indebtedness;

b. pension liabilities;

c. retiree health benefits;

d. captive insurers;

e. capital leases;

f. asbestos abatement; and

g. joint venture interests that may not transfer

Response:

Outstanding indebtedness. ECHN will be required to use the net proceeds of the transaction for defeasance of its outstanding bond and other indebtedness as VHS Eastern CT will not be assuming this debt. There is no adjustment applied to the Purchase Price relating to outstanding indebtedness.

Pension and retiree health benefits. In order to ensure that ECHN's pension obligations will be satisfied, ECHN negotiated to have VHS Eastern CT assume these liabilities. The Purchase Price will be reduced by the actuarial funding shortfall of both plans at the time of closing. As of the last actuarial review, conducted on September 30, 2014, the Purchase Price will be reduced by $45,990,000.

Captive insurers and Worker's Compensation. ECHN negotiated to have VHS Eastern CT assume Connecticut Healthcare Insurance Company's liability due to limited options and the

prohibitive cost associated with pursuing a loss portfolio transfer in the insurance market. The other potential option, not deemed acceptable due to unforeseen risk, was having Connecticut Healthcare Insurance Company retain post-closing responsibility to wind-down the captive. As a result of negotiations between the Parties, an $8,000,000 adjustment will be made to the Purchase Price at the Closing. In addition, the Worker's Compensation liability also will be assumed by VHS Eastern CT. As a result of negotiations between the Parties, a $3,500,000 adjustment for the Worker's Compensation liability will be made to the Purchase Price at the Closing. ECHN, however, reserves the right to retain either or both of these liabilities and pursue tail insurance and/or a loss portfolio transfer.

Capital leases. Tenet will assume ECHN's capital lease obligations, which are primarily for equipment purchased by ECHN with a lease term of five years or less. The Purchase Price adjustment based upon outstanding capital lease principal as of September 30, 2014, will be $9,984,000.

Asbestos abatement. VHS Eastern CT will assume the asbestos abatement liability, which relates to an accounting matter, whereby the Financial Accounting Standards Board (FASB) issued Financial Interpretation Number 47 in 2005, requiring an entity to recognize the future cost of removing asbestos to the best of their ability. ECHN recognized this liability in fiscal year ending September 30, 2006, as that was the first year affected by the new FASB ruling. The Purchase Price adjustment for asbestos abatement will be $412,000.

Joint venture interests. ECHN has not yet identified an absolute value related to the joint ventures as a whole or separately that will be deducted from the Purchase Price if not transferred. It is the expectation per the APA to transfer all joint ventures to VHS Eastern CT. The value of the joint ventures is included in the total Purchase Price. If any joint venture interest is not transferred to VHS Eastern CT, it is ECHN's intent to sell its interests in such joint ventures to a third party.

The amounts above show the anticipated plan for payment of debt and pension obligations as well as payment of other liabilities but are subject to adjustment at closing.

34. How, if at all, will non-approval by any of the joint venture interests referred to in Question 32(g) above affect the Asset Purchase, other than an adjustment of the purchase price?

Response:

Other than an adjustment of the Purchase Price, there will be no other impact on the Asset Purchase if any of the joint venture interests do not approve the change in ownership.

35. Please explain in detail the terms of the Capital Commitment and in particular:

a. How it will be allocated as between MMH and RGH, including the annual amounts projected to be available to each hospital;

b. The capital projects for each of the hospitals that are deemed top priorities by the Applicants; and

c. The service improvements for each of the hospitals that are deemed top priorities by the Applicants.

Response:

a. The $75 million has been committed to VHS Eastern CT, but has not been specifically designated as to what portion would be allocated to each hospital, its ambulatory providers or home health agency. To effectively manage a risk based payment system, a complete continuum of care to deliver services at the right place at the right time must be supported with capital investments in information technology and alternative ambulatory sites of care. It has also not been determined what portion would be allocated to each of the five years. By nature, capital projects can have multiple phases and span across several years. As such, the capital spent will most likely not be spread equally over the five years. Tenet will seek the input of the Local Boards and medical staff in making those determinations.

   The following capital projects for the hospitals have been identified by ECHN management. Aside from renovations to the MMH emergency department planned for the benefit of our behavioral health patients, they are not budgeted for fiscal year 2015. Funding for the remaining projects is dependent on the closing of the transaction with VHS Eastern CT. The projects will require the approval of VHS Eastern CT with input of the Local Boards.

   The following are the five priority capital projects in terms of medical equipment and information technology that ECHN's senior management has identified for the hospitals:

   1. Electronic medical record system replacement (MMH & RGH): $20,000,000
   2. Hematology analyzer replacements (MMH& RGH): $700,000
   3. CT scanner replacements (MMH): $850,000
   4. SPECT scanner replacement (MMH): $325,000
   5. Vessel sealing systems (MMH & RGH): $530,000

   The following are the priority capital projects in terms of construction and renovation of the hospital buildings that ECHN's senior management has identified for the hospitals:

   1. Upgrades to emergency department for behavioral health patients (MMH): $750,000
   2. Upgrades to nursing units (RGH): $1,650,000
   3. Upgrade to OR (RGH): $756,000
   4. Upgrades to nursing units (MMH): $11,000,000
   5. Masonry repairs to parking garage (MMH): $175,000

b. Tenet will seek the input of the Local Boards to prioritize capital projects based on hospital and community needs.

c. Tenet will seek the input of the Local Boards to prioritize service improvements based on hospital and community needs.

36. Describe in detail how this proposal will affect the financial strength of the State's health care system and will be financially feasible.

Response:

The financial strength of the State of Connecticut's health care system will be improved with this proposal as it will lead to a stronger and more financially secure ECHN (to be known as VHS Eastern CT). Connecticut's hospitals and their affiliated hospital networks are an important part of the State's health care system. The financial strength of Connecticut's hospitals significantly contributes to the financial strength of the State's entire health care system. Financially strong hospital systems can provide access to new and innovative services and improve access to necessary services. Increased access to needed heath care services reduces the burden on State resources and improves the health status of the community.

The proposal enables ECHN to move from a small health care system to a large national health care system which offers resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. Tenet will bring the strength of its national system to the service area of ECHN and provide innovation that ECHN could not possibly do independently. In order to offer high value health care, an essential focus of health care reform, providers across the continuum must establish new relationships, infrastructure and capabilities to provide cost efficient care. A tremendous investment is necessary in information systems, which few small hospital systems can afford. This proposal will allow VHS Eastern CT to benefit from advanced information systems that allow clinical integration and coordination of care. Once a needs analysis of the service area has been completed, YNHHS intends to assist the VHS Eastern CT to provide needed high quality clinical services to serve the population.

Hospital capital needs are significant and necessary in order to offer the latest technology and competitive facilities. Physical plant renovations are constantly required just to keep hospitals in good working order. For many hospitals like those affiliated with ECHN, the capital needs are large and cannot be met with current avenues for funding.

ECHN is facing a $7.5 million reduction in funding next year. ECHN has already experienced government cutbacks in reimbursement of over $7.8 million in the last 3 years and it is facing a loss of over $2.6 million in State funding in FY2015. With costs going up, and reimbursement going down, remaining a small hospital system will result in a further drain on its financial resources.

Tenet offers both financial strength and health care experience, with the latter, further enhanced by the Regional Provider through its partnership with YNHHS. Tenet is prepared to make the necessary investments, and has the financial resources to pay for this

investment without borrowing. These investments will strengthen VHS Eastern CT, an integral part of Connecticut's health care system. The proposal is financially feasible, and will add to the strength of the State's health care system.

37. Please provide the current payer mix for each of MMH and RGH and the projected payer mix for each respective hospital after the Asset Purchase (based on the number of patients, not based on revenue) in the following reporting format:

Table 6: Patient Population / Payer Mix

Manchester Memorial	Current	Year 1	Year 2	Year 3
Medicare [1]	41.29%	41.29%	41.29%	41.29%
Medicaid [2]	16.04%	16.04%	16.04%	16.04%
CHAMPUS or TriCare	0.39%	0.39%	0.39%	0.39%
Total Government Payers	**57.73%**	**57.73%**	**57.73%**	**57.73%**
Commercial Insurers [1]	38.99%	38.99%	38.99%	38.99%
Uninsured	2.70%	2.70%	2.70%	2.70%
Workers Compensation	0.58%	0.58%	0.58%	0.58%
Total Non-Government Payers	**42.27%**	**42.27%**	**42.27%**	**42.27%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Rockville General	Current	Year 1	Year 2	Year 3
Medicare [1]	29.55%	29.55%	29.55%	29.55%
Medicaid [2]	16.41%	16.41%	16.41%	16.41%
CHAMPUS or TriCare	0.56%	0.56%	0.56%	0.56%
Total Government Payers	**46.52%**	**46.52%**	**46.52%**	**46.52%**
Commercial Insurers [1]	48.56%	48.56%	48.56%	48.56%
Uninsured	4.06%	4.06%	4.06%	4.06%
Workers Compensation	0.86%	0.86%	0.86%	0.86%
Total Non-Government Payers	**53.48%**	**53.48%**	**53.48%**	**53.48%**
Total Payer Mix	**100.0%**	**100.0%**	**100.0%**	**100.0%**

(1) Includes managed care activity

(2) Includes managed care activity and other medical assistance

38. Provide the assumptions used to project the patient population/payer mix after the proposed Asset Purchase.

Response:

The current payer mix is based on fiscal year 2014 (October 1, 2013 – September 30, 2014). The patient population mix is not expected to change as a result of the Asset Purchase Agreement. Therefore, we would assume the exact patient population mix for the first three years after the acquisition.

39. Please provide one year of actual results and three years of projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

a. Financial Attachment 1(A) for ECHN without the CON project (columns 1, 2 5, 8 & 11) and for VHS with the CON project and incremental to the CON project (remainder columns); and

b. Submit Financial Attachment 1(A) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Note that the actual results for the fiscal year reported in the first column must agree with ECHN's audited financial statements. The projections must include the first three full fiscal years of the project.

Response:

Financial Attachment 1(A) for ECHN without the CON project and for VHS Eastern CT with the CON project and incremental to the CON project has been included in Exhibit 31. Financial Attachment 1(A) has been provided using the same page and print layouts as provided by OHCA.

40. Provide the assumptions utilized in developing Financial Attachment 1 (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense percentage increases, project commencement of operation date, etc.).

Response:

The assumptions utilized in developing Financial Attachment 1(A) are included as Exhibit 32.

41. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of VHS, MMH or RGH.

Response:

There are no projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of VHS Eastern CT.

42. Please describe any anticipated change to existing reimbursement contracts with payers (e.g., Medicare, Medicaid, commercial) as a result of the Asset Purchase.

Is it assumed in the financial projections that VHS will willingly negotiate with the payers that ECHN currently has contracts with?

Response:

VHS Eastern CT will accept all existing contracts with payers and will complete a Change of Ownership process with commercial payers, as well as the Centers for Medicare and Medicaid Services.

43. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of ECHN's and/or each of MMH's and RGH's debt and pension obligations.

Response:

The Asset Purchase will satisfy ECHN's debt and satisfy the funding obligations of the pension plan. At the time of the close, the purchase price paid by Tenet less all adjustments will be combined with ECHN's cash, investments, and debt service reserve funds (but excluding the restricted charitable funds remaining), to fully satisfy all debt. Pertaining to the pension plan, Tenet will assume full responsibility for satisfying all annual funding obligations post-closing. The funding gap of the pension plan will be deducted from the purchase price of $105 million in consideration for assuming this liability. The current underfunded status of the plan as of the last measurement date of September 30, 2014 was $43.1 million.

Table 7 below summarizes the net proceeds and flow of funds. Although the amounts below are subject to adjustment to the closing date, the table below shows the anticipated plan for payment of debt and pension obligations as well as payment of other liabilities. A portion of the post-closing surplus will be used to fund necessary wind-down operations and legal obligations of the ECHN legacy entity (e.g., tax filings). The surplus amount shown below is not assured.

Table 7. ECHN			
NET PROCEEDS ANALYSIS			
			9/30/2014
ACQUISITION PRICE (Enterprise Value)*	A		$105,000,000
ASSUMED LIABILITIES:			
Pension & Retiree Medical			($45,990,000)
Captive & Workers Compensation			($11,500,000)
Net Working Capital True-up			($8,258,000)
Capital Leases			($9,984,000)
Asbestos Abatement Liability			($412,000)
TOTAL ACQ LIABILITIES	B		($76,144,000)
NET PROCEEDS (CASH to ECHN)	C	A-B	$28,856,000
CASH & INVESTMENTS (ECHN Current)**	D		$63,442,000
TOTAL CASH available for DEBT DEFEASANCE	E	C+D	$92,298,000
LONG TERM DEBT (net bond indenture assets)	F		($79,063,000)
SURPLUS after DEBT DEFEASANCE ***	G	E-F	$13,235,000
* Acquisition Price assumes $24 million paid for target Net Working Capital to be "trued up" at closing.			
** Does not include Restricted Charitable Funds remaining nor does it include 3rd Party Net Receivables not assumed by Tenet.			
*** $7.5 million to be held as an Indemnity Reserve per the APA and held outside the Community Foundation.			

44. For each of MMH and RGH, please address the following regarding staffing at the hospital by completing "Staffing Attachments I&II."

    a. Provide the levels of staffing for fiscal year ("FY") 2013 broken out as follows:

        (i) Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the hospital;

        (ii) The same information as provided in subsection (a)(i) above showing the RN to patient ratio only; and

        (iii) The average nursing hours per patient day (NHpPD) for each department and/or unit of the hospital (all nursing staff should be included in the calculation of nursing hours).

b. Provide the projected levels of staffing by department and/or unit for the hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:

(i) **Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the Hospital; and**

(ii) **The same information as provided in subsection (b)(i) above showing the projected RN to patient ratio only.**

Response:

Please see Exhibit 33 for the completed Staffing Attachment I & II.

Staffing Attachment I has been completed for FY 2013 and FY 2014. Additionally, the budgeted ratios for FY 2015 have been provided.

45. For each of MMH and RGH, provide a detailed explanation by department and/or unit as completed by the Applicants in Staffing Attachment I, to reconcile any differences between FY 2013 nursing staff levels and those projected for the first three (3) full FYs following approval of the Asset Purchase.

Response:

ECHN, like most Connecticut health systems, continues to experience significant financial challenges that include major reductions in reimbursement, the continued taxation of hospitals by the State, increased operating costs and declining patient volumes. Given these deteriorating financial conditions, ECHN implemented a number of operational changes, including staffing changes, to mitigate the impact of expected financial losses at the start of FY 2015. In most cases, staffing reductions were realized through the elimination of non-clinical, administrative and managerial positions and a hiring freeze of open positions. In a small number of instances, staffing reductions occurred in areas experiencing patient volumes that were significantly below budgeted projections, and the staff reductions incurred are reflective of this decline in service utilization.

Given the financial challenges and operational changes discussed above, the nursing staff levels projected for the first three (3) full fiscal years following approval of the Asset Purchase are expected to remain at staffing levels budgeted by ECHN for FY 2015. This expectation is contingent upon volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, and technology. The projected nursing staff levels assume that there is no significant change in the above listed factors that would necessitate a change in the staffing levels.

Tenet expects very close to 100% of all employees, including patient care staff, to accept employment with a Tenet affiliate. Based on previous acquisitions utilizing similar APA

language and process of transition of employment, Tenet has experienced employee transition rates close to 100%.

In the event that any staffing shortfalls are identified in any of the areas across VHS Eastern CT, Tenet has experience in all areas of recruitment. VHS Eastern CT would have immediate access to Tenet's network of recruitment sites and advertising and recruitment experts at both the regional and national level. Tenet also possesses best practice strategies that can be deployed in the case of any shortages and are based on employee type. These strategies would normally include both recruitment and retention.

Tenet has experience in recruiting all types of staff including nursing, in areas of short-term and longer-term shortage situations based both on position experience and geographical shortages. Tenet's recruitment plans include several specific strategies to include:

- A multi-layered and broad-based national recruitment plan which allows for national, regional, and local geographical nuances;
- Job board recruitment contracted nationally and available throughout the United States;
- Analysis of national recruitment efforts related to results/outcomes;
- Use of behavioral assessments to identify the most qualified, "best-fit" candidates to ensure continued retention which is even more important during specific shortage situations
- Search engine optimization and search engine marketing are used to maximize our recruitment advertisements outreach and visibility; and
- Employee referral programs which help Tenet to recruit talented colleagues of current employees.

Tenet is committed to providing access to high quality care to the communities it serves, and consequently staffs its operations to ensure that commitment. The projections detailed in the application assume modest outpatient growth and flat inpatient growth, with the current service mix at ECHN projected to continue with VHS Eastern CT. Consequently, given the modest volume growth predicted, there is no material change projected in staffing levels.

However, Tenet intends to make significant capital investments which the Applicants believe will drive additional volumes. How much and in what clinical areas will be identified subject to a comprehensive long term strategic planning process. This planning process will include local management teams, medical staff leadership and representatives from the local governing board. The expectation will be new ambulatory access points around the community served resulting in increased access for patients and increased jobs for caregivers.

Tenet's acquisition of the Detroit Medical Center ("DMC") in Detroit, MI serves as an example where access and quality have improved post acquisition. Using data from 2010-2014, Tenet has invested $80 million in 146,000 square feet of ambulatory construction (including the 106,000 square foot Children's Hospital of Michigan Specialty Center). Since 2010, outpatient visits have grown 30% and employed physicians have grown from 60 to 201 providers.

Overall, clinical staffing ratios at DMC have seen a slight decrease in the overall patients per RN average ratio. This result is consistent with maturation of quality improvement programs as processes become standard, clinical variation is minimized and efficiencies are achieved. Additionally, investments have been made in workflow information technology, which also have increased efficiencies. All quality metrics have been maintained or improved since the transaction as evidenced by CMS Hospital Compare and Leapfrog.

46. For each of MMH and RGH, describe any other hospital-employed or hospital-contracted staff besides nursing staff (e.g., hospitalists, mid-level providers, therapists, etc.) that were engaged to provide direct patient care at the hospital (collectively, "Ancillary Caregivers") for FY 2013 broken out as follows:

a. The type of Ancillary Caregivers and the department and/or unit to which such staff was assigned;

b. The average number of hours per week that such Ancillary Caregivers provided patient care for the department and/or unit; and

c. For the first three (3) full FYs following approval of the Asset Purchase, the average number of hours per week that such Ancillary Caregivers are projected to provide patient care for each department and/or unit of the hospital described in subsection (a) above.

Response:

Please see Exhibit 34 for the completed Staffing Attachment I & II.

Staffing Attachment I has been completed for FY 2013 and FY 2014. Additionally, the budgeted weekly hours for FY 2015 have been provided.

47. For each of MMH and RGH, provide a detailed explanation by department and/or unit to reconcile any differences between the average number of hours per week that the Ancillary Caregivers described in Question 46 above provided patient care in FY 2013 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

Response:

Given the financial challenges and operational changes discussed in our response to Question 45 above, Ancillary Caregiver staffing levels projected for the first three (3) full fiscal years following approval of the Asset Purchase are expected to remain at staffing levels budgeted by ECHN for FY 2015. This expectation is contingent upon volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, and technology. The projected Ancillary Caregiver levels assume that there is no significant change in the above listed factors that would necessitate a change in the staffing levels.

Tenet expects very close to 100% of all employees, including ancillary care providers, to accept employment with a Tenet affiliate. Based on previous acquisitions utilizing similar APA language and process of transition of employment, Tenet has experienced employee transition rates close to 100%.

Please refer to the response to Question 45 above for more information on Tenet's strategies for addressing staffing shortfalls in shortage areas, the impact of anticipated capital investments on service delivery and caregiver jobs, and specific examples of efforts implemented at DMC to improve the quality of care delivered with slight decreases in the overall patients to Ancillary Caregiver average ratios.

48. For each of MMH and RGH, provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for the first three (3) full FYs following approval of the Asset Purchase meet all Connecticut Department of Public Health ("DPH") staffing requirements and assure continued access to high quality and affordable health care. Be sure to cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

Response:

Proposed staffing levels for nursing staff and Ancillary Caregivers following approval of the Asset Purchase will be consistent with the budgeted FY 2015 levels. The current and proposed staffing levels at MMH and RGH exceed the DPH staffing requirements as outlined in Connecticut Statute § 19-13-D3(c)-(h).[4] MMH and RGH maintain compliance with this statute and are consistently able to demonstrate this compliance to DPH surveyor's as requested.

The specific regulation pertaining to nursing staff ratios is as follows:

Department of Public Health § 19-13-D3(e) Nursing service.

(1) There shall be a competent nurse, licensed in Connecticut, as director of nursing service or an equivalent position, who shall be responsible to the administrator for nursing service in the hospital.

[4] http://www.sots.ct.gov/sots/lib/sots/regulations/title_19/013d.pdf

(2) The ratio of patients to registered nurses on duty throughout the hospital shall at no time exceed twenty-five patients or fraction thereof to one registered nurse.
(3) The ratio of patients to all nursing staff, registered nurses, licensed practical nurses and other nursing attendants on duty in the hospital shall not exceed seven patients, or fraction thereof, to one from 7 a.m. to 7 p.m., and fifteen patients, or fraction thereof, to one from 7 p.m. to 7 a.m.
(4) If there is an in-patient obstetrical department, the following shall apply:
    (A) The ratio of all nursing staff to patients for obstetrical services shall be no less than one nurse to each ten patients, or fraction thereof, on the 7am to 3pm shift; no less than one nurse to each fifteen patients, or fraction thereof, on the 3pm to 11pm shift; and no less than one nurse to each twenty patients, or fraction thereof, on the 11pm to 7 am shift;
    (B) there shall be at least one registered nurse on duty at all times. For obstetrical services with a census of twenty or more patients, there shall also be a registered nurse on duty for overall supervision of the unit;
    (C) these ratios shall be calculated without inclusion of newborns or pediatric patients.

Staffing Attachment II (provided with the response to question 44) shows the projected staffing levels for nursing staff by hospital unit. The maximum number of patients per nurse on the first and second shifts is 6.25, which is below the regulatory ceiling of 7 patients per nurse. The maximum number of patients on the overnight shift is 12.5, and this is also below the maximum number of fifteen patients per nurse allowed by the regulation from 7pm to 7am. Based on the information presented in Staffing Attachment II, the proposed nurse staffing level meets all DPH nursing staffing requirements.

ECHN utilizes the National Database of Nursing Quality Indicators (NDNQI) for unit-level benchmarks to establish appropriate nursing staff to patient ratios and worked hours per patient days. Staffing ratios are derived using the NDNQI benchmark for nursing hours per patient day and the projected average daily census by hospital unit. The staffing ratios represent the number of nursing staff full-time equivalents that would be required to accommodate the average daily census of patients on each unit while still meeting the NDNQI benchmark for worked hours per patient day. Unit leaders manage staffing levels between the 25th and 50th percentiles for nursing hour per patient day as provided by NDNQI. VHS will continue to utilize the NDNQI or other comparable benchmarks to ensure continued access to high quality and affordable health care in the communities served by MMH and RGH.

49. Applicants are required to provide copies of all CMS statements of deficiencies and plans of correction (CMS Form 2567) for hospitals owned by Tenet for the two (2) most recently completed federal fiscal years. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses. No paper copies required.

Response:

It would be extremely cumbersome and time-consuming to obtain these documents as they are kept in hard-copy form at each individual Tenet-owned hospital, and there are no aggregate compilations at the corporate level. Included, however, are statements of deficiency for the following Tenet-owned hospitals: Saint Vincent and MetroWest in Massachusetts; Detroit Medical Center in Michigan; and Baptist Health System in Texas, received in FY 2014 (see Exhibit 35). It should be noted that these documents are not reflective of a hospital's quality of care. Given the vast number of health care regulations and the complexity of hospital operations, it is not unusual for hospitals to receive statements of deficiencies following a survey. Importantly, in large part, statements of deficiencies assist a hospital in maintaining patient safety by identifying issues that over time could result in patient safety issues; they generally are not, however, an indication of unsafe care or ineffective hospital operations.

Tenet owns and operates 80 hospitals across the United States. All are currently accredited by The Joint Commission ("TJC") and are subject to unannounced CMS surveys. (One of Tenet's hospitals is a critical access hospital licensed and surveyed by the state of Georgia. Another hospital is currently accredited by HFAP in good standing, and is scheduled for its initial TJC survey prior to the end of 2014.) Any Tenet hospital receiving a statement of deficiencies following a CMS survey has submitted, within the ten (10) day deadline, a plan of correction. The plans of correction submitted have been approved by CMS and those hospitals have been found in compliance at the time of re-survey. Moreover, none of Tenet's hospitals has been decertified by CMS.

Tenet's record of health and safety is credited to its robust quality program (the "Tenet Quality Program") instituted at all of its hospitals and facilities. Tenet's comprehensive quality program focuses on four key areas: (i) patient safety; (ii) service; (iii) clinical quality, variation and cost of care; and (iv) transparency. Tenet's patient safety program includes strategies to reduce serious safety events and hospital-acquired conditions and infections, all with a goal of zero patients harmed. Tenet's service program is aimed at achieving meaningful results in patient care experience by targeting performance in patient satisfaction, employee engagement and physician satisfaction. Clinical quality, variation and cost of care involve pursuing continual improvement in clinical outcomes while lowering costs through the reduction of unnecessary clinical variation. Key clinical indicators are tracked through a balanced scorecard with performance tied to the management incentive plan. Transparency is achieved by Tenet's full participation in Federal and state quality reporting programs, as well as numerous other publicly transparent evaluators of performance. Overall, principles of high reliability and transparency are the foundation of the Tenet Quality Program.

In addition to the strong Tenet Quality Program, there are many other objective third party indicators that demonstrate Tenet's commitment to quality and safety. Tenet has achieved the following quality indicators:

1. LeapFrog Safety Scores – hospitals performing well above national average. See Exhibit 36, for most recently reported LeapFrog Safety Scores.

2. 26 facilities recognized as TJC top performers on key quality measures (See Exhibit 37)

3. TJC Disease-Specific Certification – 81 Disease-Specific Certification designations

4. 8 Magnet Hospitals – hospitals identified by the American Nurses Credentialing Center as having exceptional nursing standards as well as a good work environment for nurses

5. 1 Pathway to Excellence Hospital – identified by The American Nurses Credentialing Center as a positive work environment for nurses

6. 10 Breast Cancer Centers achieving accreditation by the American College of Surgeons

7. 5 Trauma Centers verified by the American College of Surgeons with resources to provide optimal trauma care

8. 3 hospitals nationally recognized by U.S. News and World Report and 12 hospitals recognized as high performers

9. American Heart Association Get With The Guidelines Awards

    a. Stroke Recognition (30 Hospitals on Target Stroke Honor Roll-highest recognition, 32 Gold Plus, 4 Gold, 5 Silver Plus)

    b. Heart Failure Award Recognition (35 Gold Plus, 3 Gold, 8 Silver Plus = 46 hospitals out of 51 participants)

Tenet has a strong commitment to ensuring patient safety and health care quality. The Tenet Quality Program is critical to the operation of each of its hospitals and facilities and will be fully instituted in the hospitals Tenet is seeking to acquire in Connecticut.

50. Provide a copy of, and describe any changes to, any of the following policies and procedures that will be in place at MMH and RGH if the Asset Purchase is approved:

a. Hospital collection policies (including charity care and bad debt);

b. Annual or periodic review and/or revision to the hospital's pricing structure (the chargemaster or pricemaster); and

c. The annual or periodic market rate assessment for the hospital.

Response:

a. Hospital collection policies are included in Exhibit 38. There are no planned changes to these policies.

b. The chargemaster is provided to OHCA on a monthly basis. The structure would remain unchanged if the Asset Purchase is approved. The chargemaster is generally adjusted annually for inflation and/or market adjustments.

c. Not applicable.

51. MMH and RGH have provided OHCA with their annual FY 2014 pricemasters, which were most recently updated for the months of April, 2014, respectively. With respect to these submissions and for each of MMH and RGH, please answer the following:

Note: This question assumes separate pricemasters were submitted for each hospital. Please correct if this is not the case.

a. Will the pricemaster change as a result of the Asset Purchase?

b. If so, please identify any anticipated increases or decreases to the pricemaster as a result of the Asset Purchase.

c. Please quantify the overall percentage increase or decrease in the pricemaster that is anticipated in subsection (b) above and explain the rationale for such change.

Response:

a. No. The pricemaster will not change as a result of the Asset Purchase, but VHS Eastern CT will conduct periodic reviews of the pricemaster, as it currently does.

b. Not applicable.

c. Not applicable.

52. Please provide monthly financial statistics reports for FY 2014, current month and year to-date, and comparable period for FY 2013 to OHCA, for each of MMH and RGH only and for ECHN, with the Application and thereafter on a monthly basis for each month (formatted side by side), until a public hearing in this matter is held.

The following financial measurements/indicators should be addressed in the reports:

Monthly Financial Measurements/Indicators
A. Operating Performance

a. Operating Margin
b. Non-Operating Margin
c. Total Margin
d. Bad Debt as % Gross Revenue

B. Liquidity
a. Current Ratio
b. Days Cash on Hand
c. Days in Net Accounts Receivables
d. Average Payment Period

C. Leverage and Capital Structure
a. Long-term Debt to Equity
b. Long-term Debt to Capitalization
c. Unrestricted Cash to Debt
d. Times Interest Earned Ratio
e. Debt Service Coverage Ratio
f. Equity Financing Ratio

D. Additional Statistics
a. Income from Operations
b. Revenue Over/(Under) Expense
c. EBITDA
d. Patient Cash Collected
e. Cash and Cash Equivalents
f. Net Working Capital
g. Unrestricted Assets
h. Credit Ratings (S&P, FITCH, and Moody's)

Response:

Exhibit 39 contains monthly OHCA financial statistics reports for FY 2014, current month and year- to- date, and the comparable period for FY 2013, for MMH and RGH only and for ECHN, with the Application.

53. Please describe in detail the corporate structure, governance, controlling body, purpose and function of the ECHN Community Healthcare Foundation, Inc. ("Foundation") after the Asset Purchase, including the identity of all members of the Foundation and their authority.

Response:

As stated in the answer to Question 11 above, with a few exceptions, the restricted charitable funds currently recorded on the books of the Foundation are in fact funds that the donors left either to MMH or RGH, and the Foundation has held them for the benefit of MMH or RGH, as the case may be. These funds will be transferred by the Foundation to MMH and RGH, respectively, prior to the Asset Purchase and will be reflected on the books of the Hospitals. Thus, by the time of the Asset Purchase, although the Foundation's

corporate structure is expected to remain in place for some time, the Foundation will not hold any restricted charitable funds except perhaps a few special purpose funds and a charitable gift annuity. After the Asset Purchase, it is contemplated that at some point the Foundation's corporate entity will be merged into its parent ECHN, which will assume ECHN Legacy functions.

At present, the Foundation is a nonstock corporation exempt under section 501(c)(3) that is a public charity under section 509(a)(1) of the Code. ECHN as the sole member of the Foundation has the right to elect and remove the Foundation's board, the right to amend its corporate documents, and the other rights conferred on ECHN by law and by the Foundation's Certificate of Incorporation and Bylaws.

The current members of the Foundation's Board of Trustees are the following:

Christopher Buchholz
Noreen P. Cullen
Darren DeMartino
Molly Devanney
Howard E. Fitts
Roberta Irish
Joyce A. Jordan
Peter J. Karl
Richard S. Kelley
Steven T. Norris
Peter F. Olson
Kathleen A. O'Neill
Dennis G. O'Neill
Eric Person
Thomas F. Scanlon
Robert A. Schwartz
Lincoln H. Streeter
M. Maher Suede
Meghan Wilson
Jeffrey M. Winnick

The terms of four Trustees, Jeffrey Winnick, Howard Fitts, Thomas Scanlon, and Peter Olson, expire in November 2014, and they are not eligible for reelection to the Board of Trustees.

After the Asset Purchase, the size of the Board is expected to be substantially smaller. It is not yet determined how small the Board will be or who will serve as a Trustee.

54. For each of MMH and RGH, provide a copy of the hospital's IRS Form 990 for the 2013 tax year and with respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H ("Financial Assistance and Certain Other Community Benefits at Cost"),

provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase.

Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community benefit categories.

In providing this information, please elaborate on the specific activities included and how the projections demonstrate VHS' commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECNH's current policies.

Response:

The IRS Tax Form 990 filed by MMH and RGH for tax year 2013 is included as Exhibit 40. VHS Eastern CT will continue to provide financial assistance and community benefits to the Manchester/Rockville area. As noted in response to Question 27, VHS Eastern CT is committed to providing the same, if not greater, financial assistance and community benefit to the local community as historically provided by MMH and RGH. Tenet's policies will be compared to ECHN's current policies, and VHS Eastern CT will utilize the policies that give greater financial assistance to the uninsured and underinsured. See Tables 8 and 9 below for 3 year projections.

Table 8. Schedule H, Part I, Section 7 - Financial Assistance				
Manchester Memorial Hospital			Projected	
		Year 1	Year 2	Year 3
a	Financial Assistance at cost	1,197,618	1,209,594	1,221,690
b	Medicaid	9,016,210	9,106,372	9,197,436
c	Cost of other means-tested gov't prog.	-	-	-
d	Total Financial Assistance	10,213,828	10,315,966	10,419,126
	Other Benefits			
e	Community health improvement services and community benefit operations	824,210	832,452	840,777
f	Health professions education	2,103,220	2,124,252	2,145,495
g	Subsidized health services	1,471,320	1,486,033	1,500,894
h	Research	263,774	266,411	269,076
i	Cash and in-kind contributions for community benefit	147,617	149,093	150,584
j	Total Other Benefits	4,810,140	4,858,242	4,906,824
k	Total	15,023,968	15,174,208	15,325,950

Table 9. Schedule H, Part I, Section 7 - Financial Assistance				
Rockville General Hospital			Projected	
		Year 1	Year 2	Year 3
a	Financial Assistance at cost	378,610	382,397	386,221
b	Medicaid	3,610,474	3,646,579	3,683,045
c	Cost of other means-tested gov't prog.	-	-	-
d	Total Financial Assistance	3,989,085	4,028,976	4,069,266
	Other Benefits			
e	Community health improvement services and community benefit operations	1,213,963	1,226,103	1,238,364
f	Health professions education	557,860	563,439	569,073
g	Subsidized health services	-	-	-
h	Research	9,131	9,222	9,314
i	Cash and in-kind contributions for community benefit	18,659	18,846	19,035
j	Total Other Benefits	1,799,614	1,817,610	1,835,786
k	Total	5,788,699	5,846,586	5,905,052

The description below identifies each category noted above and how the 2013 figures were calculated.

Manchester Memorial Hospital

- Financial Assistance - $1,162,736 – This relates to cost of charges written off as a result of the Hospital's Charity Care policies. A cost to charge ratio was applied to the gross charges written off to determine the cost of the charity care.
- Medicaid - $8,753,602 – This relates to the Medicaid Shortfall when comparing Medicaid payments to costs. The Hospital multiplied Medicaid gross charges by a cost to charge ratio to determine cost, then compared to related payments received. We also factored in the Hospital Tax and supplemental DSH payments when calculating the Medicaid Shortfall.
- Community Health Improvement Services and Community Benefit Operations - $800,204 – These benefits relate to Community Health Education ($533,983), Community Based Clinical Services ($30,147), Health Care Support Services ($65,814). Community Benefit Operations ($170,260) including dedicated staff and community health needs assessment costs. The related actual costs of these services, including staff time, supplies, purchased services and other direct expenses, were compiled to determine the amount of benefit.
- Health Professions Education - $2,041,961 – These benefits relate to Physicians/Medical Students, including the Residency Program ($848,840), Nursing/Nursing Student Education ($901,748), and Other Health Professional Education ($292,673). The expenses were calculated using actual expenses for the related education.
- Subsidized Health Services - $1,428,466 – These benefits relate to Neonatal Intensive Care. The expense was determined by our cost accounting related to the service line. Medicaid Shortfall was excluded so as not to double count the community benefit.

- Research - $256,091 – This benefit relates to expenditures related to the Cancer Registry ($235,404) and Institutional Review Committee ($20,687). The amounts were calculated using actual expenses, including staff time, supplies, purchased services and other direct expenses.
- Cash and In-Kind Contributions - $143,317 – These benefits relate to the donations of cash ($32,169) and In-Kind Donations ($111,148). The amounts were calculated using actual donations and calculations of people's time associated with the related community benefit.

Rockville General Hospital

- Financial Assistance - $367,583 – This relates to cost of charges written off as a result of the Hospital's Charity Care policies. A cost to charge ratio was applied to the gross charges written off to determine the cost of the charity care.
- Medicaid - $3,505,315 – This relates to the Medicaid Shortfall when comparing Medicaid payments to costs. The Hospital multiplied Medicaid gross charges by a cost to charge ratio to determine cost, then compared to related payments received. We also factored in the Hospital Tax and supplemental DSH payments when calculating the Medicaid Shortfall.
- Community Health Improvement Services and Community Benefit Operations - $1,178,605 – These benefits relate to Community Health Education ($92,999), Community Based Clinical Services ($961,026), Health Care Support Services ($54,866). Community Benefit Operations ($69,714) including dedicated staff and community health needs assessment costs. The related actual costs of these services, including staff time, supplies, purchased services and other direct expenses, were compiled to determine the amount of benefit.
- Health Professions Education - $541,612 – These benefits relate to Physicians/Medical Students, including the Residency Program ($137,356), Nursing/Nursing Student Education ($292,952), and Other Health Professional Education ($111,304). The expenses were calculated using actual expenses for the related education.
- Research - $8,865 – This benefit relates to expenditures related to the Institutional Review Committee. The amounts were calculated using actual expenses, including staff time, supplies, purchased services and other direct expenses.
- Cash and In-Kind Contributions - $18,116 – These benefits relate to the donations of cash ($9,280) and In-Kind Donations ($8,836). The amounts were calculated using actual donations and calculations of people's time associated with the related community benefit.

55. For each of MMH and RGH, with respect to the amounts listed on each line item within Part II of Schedule H of the Hospital's IRS Form 990 for the 2013 tax year ("Community Building Activities"), provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase.

Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of

programmatic and financial support that the hospitals will continue to provide in these community building activity categories.

In providing this information, please elaborate on the specific activities included and how the projections demonstrate VHS' commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECH's current policies.

Response:

VHS Eastern CT will continue to provide financial support for community building activities in the Manchester/Rockville area. As noted in Question 27, Tenet is committed to providing the same, if not greater, financial support and community benefit to the local community as has historically been provided by MMH and RGH. Tenet's policies will be compared to the Hospitals' current policies, and VHS Eastern CT will utilize the policies that give greater financial support related to community building activities.

See Tables 10 and 11 below for 3 year projections.

Table 10. Schedule H, Part II, Community Building Activities				
Manchester Memorial Hospital			Projected	
		Year 1	Year 2	Year 3
1	Physical improvements and housing	-	-	-
2	Economic development	974	984	994
3	Community support	1,432,164	1,446,485	1,460,950
4	Environmental improvements			
5	Leadership development and training for community members			
6	Coalition building	17,113	17,285	17,457
7	Community health improvement advocacy	5,038	5,088	5,139
8	Workforce development	347,830	351,308	354,821
9	Other	-	-	-
10	Total	1,803,119	1,821,150	1,839,362

Table 11. Schedule H, Part II, Community Building Activities				
Rockville General Hospital			Projected	
		Year 1	Year 2	Year 3
1	Physical improvements and housing	-	-	-
2	Economic development	-	-	-
3	Community support	942	952	961
4	Environmental improvements			
5	Leadership development and training for community members			
6	Coalition building	115	117	118
7	Community health improvement advocacy	1,755	1,773	1,790
8	Workforce development	175	177	179
9	Other	-	-	-
10	Total	2,988	3,018	3,048

56. Please discuss whether the Asset Purchase and formation of VHS is expected to achieve an improved negotiating position with vendors and/or payers and, if such an improved negotiating position is anticipated, how it will translate into tangible savings for the consumer of health care services.

Provide a response that both describes any anticipated improvements in detail and quantifies the expected results for the consumer.

Response:

As noted in Applicants' response to Question 23, a primary objective of the transaction is to allow for a coordinated approach to care. By coordinating care among the hospitals in Manchester and Rockville and community physicians and other providers, the patient population will benefit not only from the perspective of better care and better outcomes, but also from a cost perspective.

With respect to vendors, VHS Eastern CT will be able to take advantage of Tenet's greater economies of scale and superior supply chain management, which will further reduce VHS Eastern CT's cost structure because vendors will benefit from lower unit costs in dealing with larger purchasers. In addition, with respect to payers, Tenet expects that the transaction will allow VHS Eastern CT to harness the efficiencies of combining the operations of both facilities and becoming part of an entity with lower costs. It is anticipated that these cost savings will be passed on to consumers. Moreover, Tenet expects that the transactions will allow VHS Eastern CT to offer plans in which VHS Eastern CT assumes financial risk which, with the support of Tenet, VHS Eastern CT will be in an improved position to assume.

The Applicants expect that for all of the reasons noted above and in response to Question 23, the transaction will benefit consumers from a financial standpoint, as VHS Eastern CT will have a lower cost structure and superior, cost-competitive products than it otherwise would be in a position to offer.

57. Provide details of plans to be put in place to ensure the proposed health care services provided by VHS adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards see http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Response:

ECHN offers a number of programs which address the National Standards on Culturally and Linguistically Appropriate Services (CLAS). These programs are briefly described below.

ECHN offers language assistive services which can be accessed by any hospital employee when needed for interacting with a patient or family. ECHN's primary resource is the AT&T Language Line which provides quick access to a large variety of languages over the telephone. In addition, there are resources for accessing in-person interpreters for hearing impaired patients or family members. One such resource is Family Services of Woodfield who will provide an interpreter within 15 minutes of a request. ECHN offers Assistive Listening Devices and TTY/TDD equipment. In addition there are Deaf and Hearing Impaired liaisons located at both hospital campuses.

iTi is a local company in Manchester that provides document translation services. This resource is utilized as needed to prepare patient information and education materials as well as translate medical records that may be written in a foreign language.

EHCN's commitment to cultural awareness and embracing diversity is evident through several employee education initiatives including:

- Diversity training during new employee orientation – General information about culture, belief systems, and cultural responsiveness is provided along with a case study for discussion.

- Annual staff education is provided to review services and equipment available for Deaf and Hearing Impaired patients and families.

These services will continue to be provided by VHS Eastern CT and adjusted as patient need necessitates.

58. What criteria will VHS use to offer current employees employment in the new entity?

For those employees that will be employed by VHS, what is the projected difference in salary for current employees and similarly situated employees at other hospitals operated by Tenet in similar markets?

Response:

Tenet or an affiliate will offer employment to all active employees in good standing as of the Closing, subject to the satisfactory completion of Tenet's usual and customary hiring practices, in positions and at salaries at least equal to those then being provided by ECHN and with employee benefits substantially similar to employee benefit plans offered by other hospitals operated by Tenet in similar markets. Medical staff members of the Hospitals who are in good standing as of the closing shall maintain medical staff privileges following the Closing.

EXHIBIT 1 – LETTER OF INTENT

August 8, 2013

Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040
Attention: Peter J. Karl, President and Chief Executive Officer

Re: Purchase of Substantially All of the Assets of Eastern Connecticut Health Network, Inc.

Ladies and Gentlemen:

This letter of intent ("LOI") sets forth a non-binding agreement in principle between Vanguard Health Systems, Inc. ("VHS"), Yale-New Haven Health Services Corporation ("YNHHS") and Eastern Connecticut Health Network, Inc., a Connecticut non-stock corporation (together with its affiliates, "ECHN"), covering some of the major terms and conditions of the proposed purchase by one or more affiliates of a joint venture between VHS and YNHHS (collectively, "Buyer" or "Joint Venture") of substantially all of the assets (collectively, the "Assets") of ECHN and its affiliates, including the assets associated with or used in the operation of Manchester Memorial Hospital and Rockville General Hospital (each, individually, a "Hospital," and collectively, the "Hospitals"), but specifically excluding the assets of ECHN listed on Exhibit A (the "Excluded Assets"). Each of VHS, YNHHS, and ECHN are referred to herein as a "Party" and collectively as the "Parties."

1. **The Transaction**. Pursuant to a definitive agreement or agreements to be prepared by Buyer (collectively, the "Definitive Agreement"), the transaction shall be structured as a sale by ECHN to Buyer of good and marketable title to the Assets.

2. **Purchase Price**. Subject to Buyer's completion of its due diligence review of ECHN's business and financial condition, Buyer intends to pay $135 million to ECHN as full consideration for the Assets (the "Purchase Price"), which amount shall be increased or decreased on a dollar for dollar basis by the amount by which the Net Working Capital (as hereinafter defined) of ECHN as of the Closing (as defined below) exceeds or is less than a normalized amount of Net Working Capital for ECHN mutually agreeable to the Parties. "Net Working Capital" means the difference between those usable current assets of ECHN to be purchased by Buyer and those usable current liabilities of ECHN to be assumed by Buyer, in each case as identified on Exhibit B.

3. **Payment of Purchase Price; Credits**. Buyer shall pay the Purchase Price to ECHN at Closing by wire transfer of federal funds to one or more accounts of ECHN's designation less (a) the amount, if any, of ECHN employee vacation, holiday and sick time benefits assumed by Buyer (the "Special Employee Liabilities"), but only to the extent there is any recorded financial obligation for ECHN associated with the Special Employee Liabilities and such recorded financial obligation is not included in the calculation of Net Working Capital, and (b) the book value (including current portion) as of Closing of any indebtedness assumed by Buyer (including capitalized leases and the current portion of any indebtedness so assumed), and

other liabilities of ECHN assumed by Buyer, including ECHN's unfunded pension liabilities of ECHN's defined benefit pension plan (the "ECHN Plan") and the book value of the liability relating to ECHN's post-retiree health benefit plan (the "Post-Retiree Health Plan") as of Closing. ECHN shall freeze the ECHN Plan and Post-Retiree Health Plan on or prior to the Closing.

For avoidance of doubt, ECHN's unfunded pension liabilities will be the Accumulated Benefit Obligation of the ECHN Plan as of Closing reduced by the fair market value assets of the ECHN Plan as of Closing. For purposes of the foregoing calculation, the Accumulated Benefit Obligation as of Closing shall be the Accumulated Benefit Obligation determined for purposes of ECHN's audited financial statements as of September 30, 2012 (or as of September 30, 2013 if the audit of ECHN's financial statements for the year ended September 30, 2013 has been completed prior to the Closing) and projected to Closing by ECHN's actuaries using generally accepted actuarial principles (i) reflecting the assumptions used for purposes of Note 9 of such financial statements (or the appropriate footnote in the fiscal 2013 audited financial statements) and (ii) assuming continuation of the ECHN Plan and no change in its provisions after the date of ECHN's most recent audited financial statements (other than the hard freeze of the ECHN Plan). Notwithstanding the foregoing, if the transaction is not consummated on or prior to December 31, 2013, then ECHN shall obtain an actuarial valuation of the ECHN Plan, and the Accumulated Benefit Obligation as of the Closing shall be derived from the actuarial valuation. The Parties will share equally the cost of any such actuarial valuation.

The book value of the liability relating to the Post-Retiree Health Plan shall be determined by ECHN's actuaries using generally accepted actuarial principles (i) reflecting the assumptions used for purposes of Note 9 of the financial statements (or the appropriate footnote in the fiscal 2013 audited financial statements) and (ii) assuming continuation of the Post-Retiree Health Plan and no change in its provisions after the date of ECHN's most recent audited financial statements (other than the hard freeze of the Post-Retiree Health Plan). Notwithstanding the foregoing, if the transaction is not consummated on or prior to December 31, 2013, then ECHN shall obtain an actuarial valuation of the Post-Retiree Health Plan and the book value of the liability relating to the Post-Retiree Health Plan as of the Closing shall be derived from the actuarial valuation.

It is understood that a portion of the Purchase Price will be used to defease at Closing certain long-term bond liabilities of ECHN.

4. **Encumbrances**. ECHN will convey good and marketable title to the Assets to Buyer, free and clear of all liens, encumbrances and defects in title, except for liens securing any indebtedness expressly assumed by Buyer and except for customary covenants, conditions, easements and restrictions of record affecting the real property.

5. **Liabilities; Hospital Contracts**. Except for the Special Employee Liabilities, the current liabilities of ECHN included in the Net Working Capital, any debt or other liabilities for which Buyer is receiving a purchase price credit in any amount under Section 3, and as Buyer may otherwise elect, Buyer will not assume and ECHN will remain responsible for, and

indemnify Buyer against, any and all liabilities, indebtedness, commitments or obligations of any kind whatsoever that relate to the sale of the Assets and the operation of the Hospitals and related facilities prior to the Closing. Except as otherwise specifically provided, it is the intent of Buyer to assume and remain liable for those contracts, leases, and agreements presently utilized in the operation of the Hospitals that are of reasonable and ordinary scope, compensation and duration, are not unreasonably burdensome on Buyer's operation of the Hospitals, and do not violate federal, state or local laws or regulations.

6. **Capital Commitment**. Buyer believes there is tremendous opportunity to expand the services of ECHN and to establish the system as a leading provider. Buyer is committed to developing a capital strategy to help accomplish this goal. Buyer will work closely with leaders of the Hospitals, physicians and members of the Board of Trustees of the Hospitals to develop a strategy which links the capital strategy for the Hospitals to a carefully planned capital strategy. Within the five years following the Closing, Buyer commits to invest, or cause third parties to invest, $75 million in capital for the improvement of ECHN facilities and the development or acquisition of ambulatory sites and other strategic assets that benefit the Hospitals and their surrounding communities. This capital commitment is subject to a detailed strategic analysis by ECHN and Buyer, and potentially an outside consultant, to identify the opportunities that create the greatest return on investment. Select investments may also be contingent upon a targeted return on invested capital. Compliance with this investment commitment will be reported to ECHN in a written report on an annual basis that ECHN may share with the public.

7. **Additional Terms and Conditions**. The additional terms and conditions set forth in Exhibit C are incorporated by reference into this LOI.

8. **Continuation of ECHN's Operations**. From the date hereof until Closing, ECHN shall continue to operate the business of the Hospitals and other facilities in the ordinary course of ECHN's business, including, without limitation, making all normal and planned capital expenditures (based on the capital budget modified as of June 2013). Without Buyer's prior consent, ECHN shall not (a) remove or transfer any of the Assets other than in the ordinary course of business (with replacement of any transferred Assets necessary to the ordinary course operation of the Hospitals), (b) make any material change in ECHN's business or the operation of the Hospitals or other facilities or (c) enter into any significant agreement, commitment or transaction other than ECHN's customary annual line of credit renewal with TD Bank in the currently issued amount with respect to the Assets or either Hospital's business without consulting Buyer in advance and providing Buyer adequate opportunity to review and respond to any such proposed agreement, commitment or transaction; provided that VHS and YNHHS acknowledge that ECHN is planning to enter into an agreement with a provider of hospitalist services.

9. **Closing**. The closing of the transaction contemplated in this LOI shall occur on (a) the date all regulatory approvals for the transactions are obtained or (b) such other date as the Parties may mutually agree (the "Closing"). The Closing is conditioned, among other things, on: (i) mutual agreement on the terms and conditions of the Definitive Agreement that incorporate and are consistent with the terms of this LOI, and include such other provisions as the Parties

may mutually agree; (ii) all necessary regulatory approvals, including certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, approval for conversion of the Hospital to for-profit status by the Attorney General of the State of Connecticut; (iii) the waiting period under the amendments to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (the "Hart-Scott-Rodino Act") shall have expired without any challenge by the Federal Trade Commission or the United States Department of Justice to the implementation of the transaction; (iv) the Parties shall have obtained all third party approvals and consents that may be required under ECHN's material contracts, agreements, leases and licenses that are assumed by Buyer in connection with the transaction (the "Consents"), and any conditions imposed in connection with such Consents shall be reasonably acceptable to Buyer, or such Consents shall have been waived in writing by Buyer; (v) the absence of a material adverse change affecting ECHN and its business or the Assets; (vi) the receipt by Buyer of acceptable environmental, engineering and title insurance reports and policies and ALTA land title surveys; (vii) the receipt by Buyer of an opinion of counsel to ECHN reasonably satisfactory to Buyer; (viii) the Connecticut legislature shall have amended the corporate practice of medicine statute to allow stock corporations and other for-profit entities, whether incorporated or organized in Connecticut or another jurisdiction, to own medical foundations that employ physicians, or the Parties shall have found a mutually agreeable alternative structure to facilitate the ability of the Hospitals and physicians to be clinically aligned; and (ix) the satisfaction of other conditions customary in transactions of a similar nature and acceptable to the Parties.

10. **Due Diligence, Etc**. Following execution of this LOI, Buyer shall proceed promptly to evaluate and review ECHN's business and the Hospitals, and the Parties shall prepare and negotiate the Definitive Agreement. ECHN shall have the right to evaluate and review the business of and relationship between VHS and YNHHS. Buyer shall be responsible for preparing the initial draft of the Definitive Agreement. Pending execution of the Definitive Agreement and subject to limitations under law including, without limitation, antitrust, privacy and employment laws, ECHN shall give Buyer full and complete access to ECHN's businesses and operations, including the Hospitals, such that Buyer may perform its due diligence. Each of the Parties shall cooperate with each other in the due diligence process and respond to all reasonable requests of other Parties.

11. **No Violation**. With the exception of any agreements that are to be terminated at Closing (*e.g.*, debt instruments), this LOI, and the transactions contemplated hereby, will not violate any agreement, understanding, commitment or other arrangement binding on ECHN or its affiliates or to which ECHN or its affiliates are subject. Buyer has prepared and delivered this LOI in reliance on ECHN's representation above.

12. **Confidentiality; Hart-Scott-Rodino Act; Expenses; Governing Law**.

(a) Except as provided below and except as otherwise required by law, the Parties agree to keep this LOI and its contents confidential and not disclose the same to any third party (except to attorneys, consultants or accountants hired by either Party, ECHN's partnering work group or applicable governmental agencies) without the written consent of the other Parties, such

consent not to be unreasonably withheld with respect to disclosures to lenders or credit enhancers. The Confidentiality Agreement, dated as of June 29, 2012 (the "Confidentiality Agreement"), between VHS and ECHN shall remain in effect.

(b) The Parties will consult with each other before issuing or making any public reports, statements or releases with respect to this LOI or the transactions contemplated hereby, and will use good faith efforts to obtain each other's approval of the text of any public report, statement or release to be made on behalf of such Party. If a Party is unable to obtain the approval of its public report, statement or release from the other Party and such report, statement or release is, in the opinion of such Party's legal counsel, required to discharge the Party's legal obligations, then such Party may make or issue the legally required report, statement or release and shall promptly furnish the other Parties with a copy thereof.

(c) Each of Buyer and ECHN shall file a notification and report form pursuant to the Hart-Scott-Rodino Act as soon as possible after the execution of the Definitive Agreement, provided that Buyer and ECHN shall exchange drafts thereof prior to the actual filing and the Parties shall split the cost of the filing fee due in respect of such filings.

(d) Each Party shall bear its own expenses in connection with this LOI and the transaction, regardless of whether the Definitive Agreement is executed. Buyer shall be responsible for the costs of conducting its due diligence review of the Assets. The cost of title insurance, land surveys, documentary stamps, transfer taxes, recording fees and similar Closing costs shall be the responsibility of the Buyer.

(e) This LOI shall be governed by the laws of the State of Connecticut, without regard to its conflict of law provisions.

13. **Exclusive Negotiations.**

(a) For purposes of this Section 13, the term "Exclusivity Period" shall mean the period beginning on the date of execution of this LOI and ending on the date ninety (90) days thereafter. The Buyer will not enter into any other letter of intent or agreement within the Exclusivity Period relating to the acquisition, management or other control of any acute care hospital within Hartford or Middlesex Counties, Connecticut.

(b) In consideration of the substantial time and expense to Buyer in analyzing ECHN's business, in conducting its due diligence investigations and in preparing this LOI and the Definitive Agreement, during the Exclusivity Period, ECHN will not, and will not permit any person acting for or on its behalf, to: (i) offer for sale the Assets (or any material portion thereof) or any ownership interest in any entity owning any of the Assets; (ii) solicit offers to buy all or any material portion of the Assets or any ownership interest in any entity owning any of the Assets; (iii) hold discussions with any person (other than Buyer) looking toward such an offer or solicitation or looking toward a merger or consolidation of any entity owning any of the Assets; or (iv) enter into any agreement with any person (other than Buyer) with respect to the sale or other disposition of the Assets (or any material portion thereof) or any ownership interest in any

entity owning any of the Assets or with respect to any merger, consolidation, or similar transaction involving any entity owning any of the Assets.

(c) The Definitive Agreement will provide that if Buyer or ECHN fails to fulfill its obligations to close the transaction under the Definitive Agreement other than for cause as permitted by the Definitive Agreement (the "Terminating Party"), such Terminating Party shall pay to the other Party a breakup fee equal to 3% of the notional purchase price (without any reduction for pension or other costs) called for by the Definitive Agreement.

(d) The Definitive Agreement shall provide that to the extent VHS enters into, prior to the Closing, any agreement other than with Tenet Healthcare Corporation (i) under which VHS would sell substantially all of its assets or (ii) that would effect a change of control of VHS, ECHN shall have the right to terminate the Definitive Agreement immediately for cause.

14. **Definitive Agreement**. Except for the provisions of Sections 11, 12, 13 and 14, this LOI is only an expression made in good faith of the Parties' present intentions and is not intended to be a binding agreement and shall not give rise to any legal obligations between the Parties; provided that with respect to such legally binding sections, VHS and YNHHS shall be severally liable for any breach thereof. No binding contractual agreement shall exist or be implied between the Parties unless and until Buyer and ECHN shall have executed the Definitive Agreement, which shall contain the provisions outlined herein and the representations, warranties, and other terms and conditions customary for this type of transaction, all of which must be acceptable to all Parties in their sole discretion. The omission of certain terms from this LOI is not to be construed so as to diminish the importance or materiality of such terms, and the Parties acknowledge that, in addition to the proposed terms contained in this LOI, the Definitive Agreement, if executed, will contain additional material terms. Each Party shall negotiate in good faith with the other consistent with the terms of this LOI with a view toward signing a Definitive Agreement as soon as possible after the execution of this LOI.

15. **Termination**.

(a) If either Party determines for any reason or for no reason to terminate this LOI, on or after the end of Exclusivity Period, it shall send written notice of termination of this LOI to the other Party. In such event, there shall be no liability between the Parties as a result of the execution of this LOI, any action taken in reliance on this LOI, or such termination, except with respect to the provisions of Sections 11, 12, 13 and 14, which shall survive the expiration or termination of this LOI. This LOI shall automatically expire upon expiration of the Exclusivity Period, unless extended in writing by mutual agreement of the Parties in their sole discretion.

(b) Notwithstanding anything herein to the contrary, to the extent that VHS and YNHHS do not, prior to October 31, 2013, execute a definitive agreement between themselves that will govern the Joint Venture, ECHN will have the right, at its election, to (i) continue to negotiate the Definitive Agreement with VHS and YNHHS to the extent VHS and YNHHS remain engaged in negotiations towards a definitive agreement that will govern the Joint Venture, (ii) negotiate a new letter of intent with either VHS or YNHHS individually upon

written notice by ECHN to VHS and YNHHS of ECHN's desire to continue negotiations with the selected Party, which would also require written notice of termination of this LOI by ECHN to VHS and YNHHS such that no Party is bound by any term or condition of this LOI, including but not limited to the obligations of the Parties under Sections 11, 12, 13 and 14 of this LOI, or (iii) terminate this LOI immediately upon written notice to VHS and YNHHS such that no Party will be bound by any term or condition of this LOI, including but not limited to the obligations of the Parties under Sections 11, 12, 13 and 14 of this LOI. ECHN would expect, but shall not be required, to continue negotiations with one or more Parties pursuant to options (i) or (ii) of this Section 15(b) to the extent VHS and YNHHS do not execute a definitive agreement between themselves that will govern the Joint Venture prior to October 31, 2013.

(c) Notwithstanding anything herein to the contrary, to the extent that VHS informs YNHHS or ECHN at any time that VHS has elected not to acquire, or affiliate with, any hospital in Connecticut, then: (i) no Party shall be bound by any term or condition of this LOI, including but not limited to its obligations under Sections 11, 12, 13, and 14 of this LOI; and (ii) ECHN and YNHHS may then, but shall not be required to, negotiate in good faith regarding the terms and conditions of an affiliation solely between ECHN and YNHHS.

16. **Assignment**. Neither this LOI nor the rights or obligations of the Parties hereunder are assignable in whole or part by a Party without the prior written consent of the other Parties. Any attempted assignment in contravention hereof shall be void.

17. **Successors and Assigns**. This LOI shall be binding upon and inure solely to the benefit of the Parties hereto, their successors and permitted assigns, and nothing herein, express or implied, is intended to or shall confer upon any other person or entity any legal or equitable right, benefit, or remedy of any nature whatsoever.

18. **Entire Agreement**. This LOI constitutes the entire agreement between the Parties with respect to the subject matter hereof and supersedes all other prior agreements and understandings, oral or written, between the Parties with respect to the subject matter hereof other than the Confidentiality Agreement.

19. **Amendments; No Waiver**. No provision of this LOI may be amended, revoked, or waived except by a writing signed and delivered by each Party hereto. No failure or delay on the part of any Party in exercising any right hereunder will operate as a waiver of, or impair, any such right. No single or partial exercise of any such right will preclude any other or further exercise thereof or the exercise of any other right. No waiver of any such right will be deemed a waiver of any other right hereunder.

20. **Counterparts**. This LOI may be executed in one or more counterparts (and the same may be delivered by means of facsimile or pdf file), and by the different Parties hereto in separate counterparts, each of which when executed shall be deemed to be an original but all of which taken together shall constitute one and the same agreement.

* * *

Please indicate your approval of the terms and conditions of this proposal and your intention to enter into these negotiations by executing it in the space provided below and returning one executed copy to Buyer, whereupon it shall proceed promptly to complete its due diligence review of ECHN and its business and to prepare the initial draft of the Definitive Agreement. Please be advised that this proposal shall expire unless there has been delivered to Buyer a fully executed copy of this letter no later than 5:00 P.M., Nashville time, on August 9, 2013.

We look forward to a successful and mutually rewarding relationship in respect of the transactions set forth herein.

Sincerely,

VANGUARD HEALTH SYSTEMS, INC.

By: _____

Title: _____

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____

Title: _____

* * *

Please indicate your approval of the terms and conditions of this proposal and your intention to enter into these negotiations by executing it in the space provided below and returning one executed copy to Buyer, whereupon it shall proceed promptly to complete its due diligence review of ECHN and its business and to prepare the initial draft of the Definitive Agreement. Please be advised that this proposal shall expire unless there has been delivered to Buyer a fully executed copy of this letter no later than 5:00 P.M., Nashville time, on August 9, 2013.

We look forward to a successful and mutually rewarding relationship in respect of the transactions set forth herein.

Sincerely,

VANGUARD HEALTH SYSTEMS, INC.

By: _____

Title: _____

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____

Title: _____

The foregoing is approved and this LOI is effective as of the 8th day of August, 2013.

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: Peter J Karl

Title: President & CEO

Exhibit A

Excluded Assets

Cash and cash equivalents

Board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, working capital trust assets, and assets and investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing

All insurance proceeds arising in connection with the operation of the Assets for periods prior to Closing to the extent that all damage to the Assets has been repaired

All amounts due or to become due to ECHN from Medicare, Medicaid, or other payor programs in respect of cost report periods ended on or prior to Closing

Interests in, and assets of, the ECHN Community Healthcare Foundation

The equity or membership interests in Northeast Regional Radiation Oncology Network, Inc. ("NRRON"), provided that the Parties will mutually explore transfer of the membership interests in NRRON to YNHHS or an entity designated by VHS and YNHHS.

Exhibit B

Net Working Capital

Current Assets

Agreed value of accounts receivable, net of allowance (excluding estimated settlements from third party payors)

Usable prepaid expenses and other current assets

Usable inventory and supplies

Current Liabilities

Accounts payable and accrued expenses

Other current liabilities

Exhibit C

Additional Terms and Conditions

1. *Employees.* Buyer recognizes the contribution of ECHN's employees to ECHN's reputation for high quality healthcare in the community, and believes that employees should take pride in, and be recognized and rewarded for, helping the Hospitals achieve their goals and fulfill their missions. Buyer (or one of its affiliates) will offer substantially all active employees of ECHN employment after Closing in their current positions and at a salary and benefit levels consistent in the aggregate with those presently being provided to them and consistent with those offered to employees of similarly situated VHS entities (subject to customary employee background checks). Buyer will assume the Special Employee Liabilities, including providing vacation, holiday and sick time credit to ECHN employees in accordance with the credits maintained by such ECHN employees as of the day prior to the Closing, subject to a Purchase Price credit for the Special Employee Liabilities assumed, but only to the extent there is any recorded financial obligation for ECHN associated with the Special Employee Liabilities and such recorded financial obligation is not already included in the calculation of Net Working Capital. Buyer will honor prior service credit under ECHN's current benefit plans for purposes of satisfying pre-existing conditions limitations in Buyer's welfare plans and eligibility and vesting requirements in Buyer's retirement plans. Buyer will upon Closing assume and become the sponsor of the ECHN Plan and the Post-Retiree Health Plan. Buyer will administer and provide COBRA benefits for any M&A Qualified Beneficiaries as defined by Internal Revenue Service regulations. Except with respect to the ECHN Plan, the Post-Retiree Health Plan, COBRA benefits and the Union Agreements (as defined herein), Buyer will not, however, assume or otherwise become liable for ECHN's other obligations to former or current employees of ECHN other than current employee liabilities except as otherwise required by law. However, Buyer will enter into a transitional services agreement at Closing with ECHN to lease employee time to ECHN for the provision of orderly wind down of benefits (excluding the ECHN Plan, which Buyer will assume), with fees for such services to be at cost.

2. *Covenant Not to Compete.* ECHN will execute and deliver at the Closing a covenant not to compete for a period of time and within a geographic area, and containing other terms acceptable to Buyer and ECHN.

3. *Allocation of Purchase Price.* The Purchase Price will be allocated among the Assets as Buyer may determine based upon their fair values consistent with Section 1060 of the Internal Revenue Code.

4. *Guarantee of Subsidiary Obligations.* VHS will guarantee the obligations of Buyer pursuant to the Definitive Agreement.

5. *Hospital Board of Trustees.* Following the Closing, Buyer will appoint an advisory Board of Trustees for each Hospital composed of community representatives, physicians on the Hospital's medical staff, and the Hospital's Chief Executive Officer. The Board of Trustees will,

among other things, be responsible for medical staff credentialing, quality assurance and accreditation of the Hospitals, in accordance with the Board of Trustee Bylaws.

6. *Captive Insurer.* At ECHN's election, the Definitive Agreement shall include assumption by Buyer of all assets and liabilities of ECHN's current captive insurer (the "ECHN Captive"). In the event the amount of the ECHN Captive's liabilities exceeds the amount of liquid assets of the ECHN Captive as of the Closing, then the Purchase Price shall be reduced on a dollar-for-dollar basis by the amount of such excess. It is agreed that the Parties would close based on an estimate of ECHN Captive's liquid assets and liabilities as of the most recent practicable date, and, if necessary, there would be a post-Closing adjustment to the Purchase Price based on actual liquid assets and liabilities of the ECHN Captive as of the Closing; provided, however, after the determination of the post-Closing adjustment, ECHN can decide to reacquire its ownership of the ECHN Captive and purchase extended reporting endorsement policies for its insurance policies.

7. *Tail Insurance.* Subject to Buyer's completion of its due diligence review of ECHN's insurance policies, ECHN will procure or otherwise fund, at ECHN's expense, extended reporting endorsement policies concerning its insurance policies.

8. *Indemnity Reserve.* The Definitive Agreement shall provide a mutually agreeable indemnity reserve for a period of three years so that Buyer will have meaningful financial recourse against ECHN for indemnification claims. Buyer acknowledges that the indemnification reserve shall not be so large that ECHN cannot satisfy all of its liabilities plus have a reasonable reserve.

9. *Continuation of Services.* For a period of no fewer than three years following the Closing, Buyer will continue operating the Hospitals as acute care hospitals with emergency departments.

10. *Compliance Program.* Buyer believes that an effective corporate compliance program improves internal communication and employee feedback to management, provides valuable information on how the company is operating, reduces the possibility of civil or criminal wrongdoing by employees, reassures its governing board and stockholders that the company is addressing employee misconduct, and generally improves the morale of all employees who are held to a common high standard of conduct. To this end, each of VHS and YNHHS has established and implemented a corporate compliance and ethics program to ensure that high ethical and conduct standards are met in the conduct of their business. For VHS, experienced officers and counsel manage the compliance program under the oversight and enforcement of VHS' Board of Directors (or a designated committee of the Board). VHS' compliance program requires every VHS director, officer and employee to attend initial and periodic compliance training programs, encourages employees to report legal or ethical violations to VHS' senior compliance officer without fear of retaliation, even on an anonymous basis, and ensures that all violations are investigated and, where appropriate, remedied. The Hospitals, and all other hospital businesses acquired by VHS, will be subject to VHS' compliance program.

11. *Clinical Quality.* Buyer shall collaborate with ECHN on clinical quality matters in order to share best practices, establish clinical quality goals and measure progress.

12. *Additional Provisions.* Additional substantive commitments made in the response by the Buyer to ECHN's request for proposal, as amended by supplemental written submissions, will be included in the Definitive Agreements. These include, but are not limited to, the following general topics:

- Buyer will support ECHN's historic, community-based mission;
- Buyer will include ECHN-affiliated physicians in the strategic planning process for clinical service lines of the new health care entity;
- Buyer will, to the extent consistent with antitrust requirements, include currently independent, ECHN affiliated physicians in managed care contracting and clinical integration for the new health care entity;
- The Definitive Agreement shall include a provision whereby Buyer (or its affiliate that employs the employees of the Hospitals) expressly assumes the collective bargaining agreements of the Hospitals (collectively the "Union Agreements");
- Buyer will provide ongoing support for ECHN's University of New England medical student and other health professions teaching programs, in addition to ECHN's graduate medical education programs, while operating at a level to not exceed the IME (Indirect Medical Education) and DGME (Direct Graduate Medical Education) caps that may be established by CMS;
- Buyer will maintain an ownership interest in ECHN's current post-acute care continuum of care network (e.g., VNA/home care, sub-acute and long term lines of service) for at least three years following the Closing, and will require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for at least three years following the Closing;
- Buyer will provide ongoing support for community volunteer services at the new health care entity, consistent with ECHN's historical practices, following the Closing;
- Buyer will develop, in consultation with ECHN, a strategic capital plan after execution of this LOI but prior to execution of the Definitive Agreement;
- Buyer will develop, in consultation with ECHN, an overall strategic plan for the new health care entity;
- Buyer will use "Yale New Haven Health Vanguard Community Network" or similar joint YNHHS-VHS branding for the new health care entity; and
- After executing the Definitive Agreement, Buyer will inform ECHN promptly if VHS and YNHHS enter into any comparable transaction with another Connecticut hospital prior to closing of the Definitive Agreement, subject to such hospital's approval of waiving any nondisclosure obligation in a confidentiality agreement between such hospital and VHS or YNHHS.

EXHIBIT 2 – ASSET PURCHASE AGREEMENT

ASSET PURCHASE AGREEMENT

by and between

EASTERN CONNECTICUT HEALTH NETWORK, INC.

SELLER

and

VHS EASTERN CONNECTICUT HEALTH SYSTEM, LLC

BUYER

Dated as of [•], 2014

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ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement, dated _____, 2014, is by and between Eastern Connecticut Health Network, Inc., a Connecticut non-stock corporation ("**Seller**"), on its behalf and on behalf of its Subsidiaries, and **VHS Eastern Connecticut Health System**, LLC, a Delaware limited liability company ("**Buyer**"), with VHS of Connecticut, LLC, a Delaware limited liability company and direct owner of Buyer ("**VHS CT**"), and Tenet Healthcare Corporation, a Nevada corporation and the indirect owner of Buyer ("**Tenet**"), joining for the limited purposes described herein.

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of The Manchester Memorial Hospital and The Rockville General Hospital, Incorporated (collectively, the "**Hospitals**"), ECHN Eldercare Services, Inc., Visiting Nurse and Health Services of Connecticut, Inc. including its wholly owned subsidiary A Caring Hand, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, Connecticut Healthcare Insurance Company, Inc., ECHN Corporate Services, Inc. including its wholly owned subsidiary Medical Practice Partners, LLC, and ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC (the entities and businesses operated by the foregoing entities, including the Hospitals, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Northeast Regional Radiation Oncology Network, Inc., Evergreen Endoscopy Center, LLC, WBC Connecticut East, LLC, Aetna Ambulance Service, Inc., Metro Wheelchair Service, Inc., Ambulance Service of Manchester, LLC, Connecticut Occupational Medicine Partners, LLC, and Eastern Connecticut Physician Hospital Organization, Inc. and Seller's Affiliates' joint venture interests in Tolland Imaging Center, LLC, Pathology Laboratory Services, LLC, Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Evergreen Medical Associates II LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**");

WHEREAS, Buyer desires to purchase substantially all of the assets, real, personal and mixed, tangible and intangible, of Seller, including the Hospital Businesses and the equity interests in the Joint Ventures; and

WHEREAS, Seller has concluded that the transactions contemplated by this Agreement are in its best interests and consistent with its charitable mission of the promotion of health to the communities served by the Hospital Businesses.

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which are forever acknowledged, the parties, intending to be legally bound, agree as follows:

AGREEMENT:

1. DEFINITIONS AND REFERENCES

1.01. Definitions. For purposes of this Agreement, the following definitions apply:

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Accumulated Benefit Obligation** means the accumulated benefit obligation of Seller's defined benefit pension plan, determined for purposes of Seller's audited financial statements as of September 30 of the most recently ended fiscal year of Seller, and projected to Closing by Seller's actuaries using GAAP (i) reflecting the assumptions used for purposes of Note 9 of such financial statements and (ii) assuming continuation of the Seller's defined benefit pension plan and no change in its provisions after the date of Seller's most recent audited financial statements (other than the freeze of such plan to new participation and future accruals). Notwithstanding the foregoing, if Closing does not occur on or prior to December 31, 2015, then Seller shall obtain an actuarial valuation of Seller's defined benefit pension plan, and the Accumulated Benefit Obligation shall be derived from such actuarial valuation. The Parties will share equally the cost of any such actuarial valuation;

(3) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. For purposes of this Agreement, any reference to Affiliates of Seller shall only mean those persons listed on Schedule 1.01(3) attached hereto.

(4) **Affiliated Group** means any affiliated group within the meaning of section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law;

(5) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a Subsidiary of Seller and held or used in connection with the operation of the Hospital Businesses, but (ii) excluding the Excluded Assets;

(6) **Assumed Contracts** is defined in Section 2.01(f);

(7) **Assumed Liabilities** means (i) the current liabilities included in Net Working Capital, but only to the extent accrued on the Closing Balance Sheets, (ii) all obligations of Seller and its Affiliates arising under the Assumed Contracts with respect

to periods (or portions thereof) following the Closing Date, (iii) all participating provider agreements and provider numbers with third party payors, including contracts and provider numbers of Government Payment Programs, to the extent the same are assignable to Buyer, (iv) the Special Employee Liabilities, (v) the Extended Illness Bank Obligations, (vi) Permitted Encumbrances, (vii) the Unfunded Pension Liabilities, (viii) the Post-Retiree Health Plan Liability and other retirement obligations described on Schedule 2.03, (ix) the Captive Insurer Liability and (x) the other liabilities and obligations agreed to be assumed by Buyer, if any, described on Schedule 2.03;

(8) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(9) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Subsidiaries for the three most recently ended fiscal years, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of Saslow Lufkin & Buggy, LLP, independent certified public accountants;

(10) **Bond Liabilities** means those certain long-term bond liabilities and tax-exempt leases of Seller to be defeased at Closing;

(11) **Buyer** is defined in the preamble;

(12) **Buyer Deductible** is defined in Section 9.04;

(13) **Buyer's Indemnified Persons** means Buyer, VHS CT, and Tenet and their respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(14) **Buyer's Plan** means a retirement plan qualified under section 401(a) of the Code that is sponsored by Buyer or one of its controlled group or affiliated service group members, as defined in section 414 of the Code;

(15) **Captive Insurer Liability** means all liabilities relating to Seller's captive insurer, the Connecticut Health Insurance Company, Inc. The book value of the Captive Insurer Liability shall be based on the Financial Statements as of September 30 of the most recently ended fiscal year of Seller.

(16) **Claim Notice** means written notification of a Third Party Claim by an Indemnitee to an Indemnifying Party under Article 9, including a Third Party Claim set forth in a "Revenue Agent's Report," "Statutory Notice of Deficiency," "Notice of Proposed Assessment," or any other official written notice from a Taxing authority that Taxes are due or that a Tax audit will be conducted;

(17) **Closing** is defined in Section 8.01(a);

(18) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the close of business on the Closing

Date, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

(19) **Closing Date** means the date upon which the Closing occurs;

(20) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing;

(21) **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(22) **Code** means the Internal Revenue Code of 1986, as amended;

(23) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which Seller or any Subsidiary of Seller is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(24) **Controlled Group** means with respect to Seller, a group consisting of each trade or business (whether or not incorporated) that, together with such Seller, would be deemed a "*single employer*" within the meaning of section 4001(a) of ERISA;

(25) **Cost Reports** means all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them;

(26) **Current Seller Plan** is defined in Section 3.22(a);

(27) **Disability Obligations** mean liabilities for long-term or short-term disability benefits to employees of the Hospital Businesses. The Disability Obligations include liabilities of the Hospital Businesses for long-term or short-term disability benefits that may have commenced being paid prior to Closing and that remain ongoing after the Closing.

(28) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with GAAP consistently applied;

(29) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained, or required to be sponsored or maintained, by such Person or to

which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

(30) **Employee Pension Benefit Plan** is defined in section 3(2) of ERISA;

(31) **Employee Welfare Benefit Plan** is defined in section 3(1) of ERISA;

(32) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(33) **Environmental Claim** means any written notice (or oral notice reduced to writing by Seller) by a Person alleging potential liability (including potential liability for investigatory costs, cleanup costs, Governmental Authority response costs, natural resource damages, property damages, personal injuries, or penalties) of Seller or any Subsidiary of Seller arising out of, based on or resulting from (i) the presence, or release into the environment, of any Materials of Environmental Concern at any location, whether or not owned by Seller, or (ii) circumstances forming the basis of any violation, or alleged violation, of any Environmental Laws;

(34) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the

Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

(35) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(36) **ERISA Fiduciary** is defined in section 3(21) of ERISA;

(37) **Excluded Assets** is defined in Section 2.02;

(38) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing, including any line of credit to which Seller is a party, the Bond Liabilities, tax-exempt leases, and any other indebtedness of Seller, any interest accrued on indebtedness of Seller, any settlements due as of Closing to third party payors, and all medical malpractice or general liability claims that relate to any pre-Closing period except to the extent reflected in the Financial Statements;

(39) **Extended Illness Bank Obligations** means the Hired Employees' accrued or allocated paid time off that is in the form of an "*extended illness bank*" (i.e., paid time off that may be used by a Hired Employee during the term of employment, but the value of the unused portion of which is not paid in cash to the Hired Employee upon termination of employment);

(40) **Financial Statements** means the Audited Financial Statements and the Unaudited Financial Statements;

(41) **GAAP** means United States generally accepted accounting principles;

(42) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(43) **Government Payment Programs** means federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Authorities;

(44) **Hill-Burton Act** means the Public Health Service Act, 42 U.S.C. §291, *et seq.*;

(45) **Hired Employees** means those employees of Seller or its Affiliates who accept Buyer's offer of employment as of the Closing Date, including those employees who are employed pursuant to an Assumed Contract;

(46) **HSR Act** means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(47) **Immaterial Contract** means any Contract to which Seller or any of its Subsidiaries is a party that requires either the payment by Seller or its Subsidiaries of $50,000 or less or the provision of goods or the performance of services by Seller or any of its Subsidiaries having an annual value of $50,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Sections 3.18(a) through 3.18(m);

(48) **Immediate Family Member** means any individual described in the definition of "*Immediate Family Member*" found at 42 C.F.R. §411.351;

(49) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 9;

(50) **Indemnitee** means any Person entitled to indemnification under Article 9;

(51) **Indemnity Notice** means written notification of a claim for indemnity under Article 9, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 9.05(b);

(52) **Indenture** is defined in Section 6.04;

(53) **Information Systems** means the software (including object and source codes as applicable), hardware, application programs and similar systems owned, licensed or leased by Seller and used in the ownership or operation of the Hospital Businesses, whether or not on a system-wide basis;

(54) **Intellectual Properties** means (i) all inventions (whether or not patentable or reduced to practice), all improvements thereto, and all patents, patent applications, and patent disclosures, together with all reissuances, continuations, continuations-in-part, revisions, extensions, and reexaminations thereof, (ii) all trademarks, service marks, trade dress, logos, trade names, corporate names, and domain names, including all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith, (iii) all copyrightable works, all copyrights, and all applications, registrations, and renewals in connection therewith, and (iv) all trade secrets and confidential business information (including ideas, research and development, know-how, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals) that are owned, licensed or leased by Seller and used in the ownership or operation of the Hospital Businesses, together with all rights to sue or make any claims for any past, present, or future infringement, misappropriation or unauthorized use of any of the foregoing rights, and the right to all income, royalties, damages and other payments that are now or may

hereafter become due or payable with respect to any of the foregoing rights, including damages for past, present or future infringement, misappropriation or unauthorized use thereof;

(55) **Interim Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the most recent month end available before the Closing;

(56) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments in any other Person, and proceeds from the sale thereof;

(57) **Local Board** means the advisory board of trustees of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing;

(58) **Leased Real Property** means the real property described on Schedule 2.01(b), together with all buildings, improvements and fixtures thereon, leased by Seller or any Subsidiary of Seller;

(59) **Legal Requirements** means, with respect to any Person, all statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(60) **Losses** means any and all damages, costs, losses (including any diminution in value), liabilities, expenses or obligations (including Taxes, interest, penalties, court costs, costs of preparation and investigation, and attorneys', accountants' and other professional advisors' fees and expenses);

(61) **Material Adverse Change** means a material adverse change, individually or in the aggregate, of the business, assets, liabilities, financial condition or results of operations of Seller and the Hospital Businesses, which taken as a whole (i) has or could reasonably be expected to have a material adverse effect upon the validity or enforceability of this Agreement or (ii) is or could reasonably be expected to be material and adverse to the Hospital Businesses or the Assets, but excluding the effect of (x) matters described in the Schedules, (y) changes in the economy of the United States in general, and (z) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut if such change does not disproportionately affect Seller or the Hospital Businesses; provided, however, that a change resulting from the downward adjustment to the Medicare wage index or the failure of the Seller to meet its debt service coverage ratio, if waived by applicable lender(s), shall not constitute a Material Adverse Change;

(62) **Materials of Environmental Concern** means chemicals, pollutants, contaminants, wastes (including Medical Waste), toxic substances, petroleum and petroleum products listed or regulated under Environmental Laws, including hazardous wastes under the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder;

(63) **Medical Waste** means any substance, pollutant, material or contaminant listed or regulated under any Medical Waste Law that is generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, and (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings;

(64) **Medical Waste Law** means the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.*, the U.S. Public Vessel Medical Waste Anti-Dumping Act of 1988, 33 U.S.C. §2501, *et seq.*, the Marine Protection, Research, and Sanctuaries Act of 1972, 33 U.S.C. §1401, *et seq.*, The Occupational Safety and Health Act, 29 U.S.C. §651, *et seq.*, the United States Department of Health and Human Services, National Institute for Occupational Self-Safety and Health Infectious Waste Disposal Guidelines, Publication No. 88-119, and any other federal, state, regional, county, municipal or other Legal Requirements insofar as they purport to regulate Medical Waste, or impose requirements relating to Medical Waste;

(65) **Multiemployer Plan** is defined in section 3(37) of ERISA or section 4001(a)(3) of ERISA;

(66) **Multiple Employer Plan** means an Employee Pension Benefit Plan that is not a Multiemployer Plan and for which a Person who is not a member of a Controlled Group that includes Seller or any Subsidiary is or has been a contributing sponsor;

(67) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Hospital Businesses acquired by Buyer, including inventory and supplies, Accounts Receivable, other receivables, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee

benefit accruals include paid time off accruals for vacation and sick time but exclude Extended Illness Bank Obligations);

(68) **Notice Period** is defined in Section 9.05(a)(i);

(69) **Owned Real Property** means real property owned (legally or beneficially) by Seller or any Subsidiary of Seller, including the real property described on Schedule 2.01(a), together with all buildings, improvements and fixtures thereon owned by Seller or any Subsidiary of Seller and all appurtenances and rights thereto;

(70) **PBGC** means the Pension Benefit Guaranty Corporation;

(71) **Permit** means each license, permit, right, franchise, concession, certificate, authorization, consent, certificate of need or other approval of a Governmental Authority owned or held by Seller or relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(72) **Permitted Encumbrances** means the Permitted Personal Property Encumbrances and the Permitted Real Property Encumbrances;

(73) **Permitted Personal Property Encumbrances** means those Encumbrances described on Schedule 3.11 as being Permitted Personal Property Encumbrances;

(74) **Permitted Real Property Encumbrances** means those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

(75) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(76) **Post-Retiree Health Plan Liability** means the book value of the liability relating to Seller's post-retiree health benefit plan, determined for purposes of Seller's audited financial statements as of September 30 of the most recently ended fiscal year of Seller, and projected to Closing by Seller's actuaries using GAAP (i) reflecting the assumptions used for purposes of Note 9 of such financial statements and (ii) assuming continuation of the Seller's post-retiree health benefit plan and no change in its provisions after the date of Seller's most recent audited financial statements (other than the freeze of such plan to new participation). Notwithstanding the foregoing, if Closing does not occur on or prior to December 31, 2015, then Seller shall obtain an actuarial valuation of Seller's post-retiree health benefit plan, and the Post-Retiree Health Plan Liability shall be derived from such actuarial valuation. The Parties will share equally the cost of any such actuarial valuation;

(77) **Prior Seller Plan** is defined in Section 3.22(b);

(78) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or

investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(79) **Prohibited Transaction** is defined in Section 5.09;

(80) **Purchase Price** is defined in Section 2.05;

(81) **Purchase Price Adjustment** is defined in Section 2.05(f);

(82) **Reportable Event** is defined in section 4043 of ERISA;

(83) **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(84) **Seller** is defined in the preamble;

(85) **Seller Deductible** is defined in Section 9.02;

(86) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Affiliates, and, for all of them, their respective members, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(87) **Special Employee Liabilities** means (i) all paid time off accruals (including vacation, holiday, and sick time benefits) of the Seller's employees (other than Extended Illness Bank Obligations), and (ii) all payments accrued as of the Closing under the Seller's long term retention payment program, culminating in 2017, but in each case only to the extent there is a recorded financial obligation for Seller associated with such liabilities and such recorded financial obligation is not included in the calculation of Net Working Capital;

(88) **Strategic Business Plan** means the strategic plan developed prior to Closing by Buyer, in consultation with Seller, and, with respect to clinical service lines, in consultation with Seller-Affiliated physicians, as the same may be amended from time to time, *provided, however*, that the Strategic Business Plan does not include the strategic capital plan referenced in Section 5.18 herein;

(89) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required

in accordance with GAAP to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(90) **Target Net Working Capital** means $24,000,000;

(91) **Tax** means any income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(92) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code section 501(c)(3) organization, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(93) **Tenant Leases** is defined in Section 3.12(i);

(94) **Third Party Claim** is defined in Section 9.05(a)(i);

(95) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*;

(96) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer will lease Hired Employees to Seller at cost for the orderly wind down of the benefits and administration of Seller's other post-Closing obligations (*e.g.*, finalizing Cost Reports), in substantially the form of Exhibit A attached hereto;

(97) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Subsidiaries as of [_____], 2015, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the [_____]-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b);

(98) **Unfunded Pension Liabilities** means the unfunded pension liabilities of Seller's defined benefit pension plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller's defined benefit pension plan as of Closing; and

(99) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq.*

(100) **Workers' Compensation Liability** means all workers' compensation liabilities of Seller and its Affiliates. The book value of the Workers' Compensation Liability shall be based on the Financial Statements as of September 30 of the most recently ended fiscal year of Seller.

1.02. Certain References. As used in this Agreement:

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Eastern Time;

(i) references to "*Seller's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02, after due inquiry by Seller of such Persons;

(j) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(k) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment located at the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned or leased by Seller or used in the conduct of the Hospital Businesses; *provided* that any such leased personal property shall be described on Schedule 2.01(c);

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical/administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

(f) all rights with respect to the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), the leases relating to the leased personal property listed or described on Schedule 2.01(c), and all Immaterial Contracts not listed or described on Schedule 2.02(j) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and the Information Systems;

(i) all property of Seller, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) the Investment interests in the Joint Ventures, including all transferable rights relating thereto;

(k) subject to Section 5.13, all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(l) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(p) and any claims relating to Excluded Assets or the Excluded Liabilities;

(m) general intangibles of the Hospital Businesses, including goodwill;

(n) cash and investments in the amount of $6,300,000 (Six Million Three Hundred Thousand Dollars), being the agreed upon amount of assets maintained by Seller and its Affiliates with respect to the Captive Insurer Liability and the Workers' Compensation Liability;

(o) Seller's provider agreements with Government Payment Programs; and

(p) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Requirements by which Seller is bound;

(b) all cash, bank accounts, certificates of deposit, treasury bills, treasury notes, marketable securities and other cash equivalents (including the Purchase Price payable to Seller) of Seller or the Hospital Businesses except for those listed in Section 2.01(n);

(c) all short-term and long-term Investments, but excluding the Investment interests in the Joint Ventures;

(d) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and Investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(e) inventory and supplies disposed of or exhausted after the date of this Agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with Section 5.02(e);

(f) Cost Report settlement receivables for periods ended on or prior to the Closing Date and all appeals and appeal rights relating thereto;

(g) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture) related to the Bond Liabilities;

(h) all deductions, benefits, claims, refunds, receivables and other rights of Seller or any Affiliate of Seller relating to Taxes in respect of periods ending on or before

the Closing Date (or portions thereof) or resulting from the consummation of the transactions contemplated by this Agreement;

(i) all other current financial assets not included in Net Working Capital and all deferred expenses;

(j) all Contracts that are listed or described on Schedule 2.02(j) and all other Contracts that are not Assumed Contracts (including this Agreement and the Closing Documents);

(k) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;

(l) the corporate or trade names set forth on Schedule 2.02(l) and all Intellectual Property rights relating thereto;

(m) all physician loans and receivables other than repayment obligations under Assumed Contracts;

(n) all right, title and interest of ECHN Community Healthcare Foundation in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(n);

(o) all insurance proceeds received by Seller or payable to Seller (i) with respect to other Excluded Assets or the Excluded Liabilities or (ii) arising in connection with the operation of the Assets for periods prior to Closing to the extent that all material damage to any such Asset has been repaired and to the extent consistent with Section 5.13 herein;

(p) the claims of Seller against third parties described on Schedule 2.02(p), appeals and other risk settlements of the Hospital Businesses which arose during or relate to a pre-Closing period, and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

(q) any other assets identified on Schedule 2.02(q) or excluded after the execution of this Agreement by mutual written agreement of the parties; and

(r) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller and its Affiliates the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03, and agrees to pay and satisfy all such Assumed Liabilities.

2.04. Excluded Liabilities. Notwithstanding anything to the contrary set forth in this Agreement, under no circumstance will Buyer assume or be obligated to pay, and from and after the Closing, none of the Assets will be or become liable for or subject to, any of the Excluded

Liabilities, which Excluded Liabilities are and will remain liabilities of Seller, including the following:

(a) all liabilities accrued on the Closing Balance Sheets, other than those included in Net Working Capital constituting Assumed Contracts;

(b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this Agreement;

(c) liabilities or obligations for federal or state income Taxes of Seller or any Affiliate of Seller, including any amounts accrued or incurred by the Hospital Businesses as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;

(d) liabilities or obligations relating to the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract);

(f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or default on or before the Closing Date of any Assumed Contracts and (iii) liabilities arising under any Contracts that are not Assumed Contracts;

(g) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 3.23, and Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that occurred on or before the Closing Date, including those relating to peer review activities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) liabilities and obligations to Seller's employees, Seller's Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods on or before the Closing Date (whether or not triggered by the transactions contemplated by this Agreement), including liabilities or obligations arising on or before the Closing Date under any Seller Employee Benefit Plan, United States Equal Employment Opportunity Commission claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act, provided that this subsection (i) shall not apply to (i) liabilities or obligations under the Employee Benefit Plans assumed by Buyer under Section 5.03(d), including but not limited to the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, (ii) Special Employee Liabilities, (iii) Extended Illness Bank Obligations, (iv) obligations under Assumed Contracts or (v) the Worker's Compensation Liability;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller, including arising out of the operation of the Hospital Businesses or ownership of the Assets, with respect to periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this Agreement, including pursuant to third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services ("**CMS**") or the Connecticut Department of Social Services and recapture of previously reimbursed charges or expenses; and

(l) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Requirement prior to the Closing Date.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and tender the Purchase Price, determined as follows, subject to the adjustments described in Section 2.05(f):

(i) $105,000,000, *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital, and *minus*

(iv) the book value (including the current portion) of any indebtedness (including capitalized leases) assumed by Buyer, and *minus*

(v) The Special Employee Liabilities, the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, and *minus*

(vi) The "additional funding" that the Buyer is requiring to be willing to accept liability for the Captive Insurer Liability (including tail liability), which is $8,000,000, and *minus*

(vii) The "additional funding" that the Buyer is requiring to be willing to accept liability for the Workers' Compensation Liability, which is $3,450,000, and *minus*

(viii) In the event Seller is unable to assign and transfer to Buyer or Buyer's designee all of Seller's Investment in each Joint Venture, an amount equal to the consideration received by Seller from the other party to the Joint Venture, in a bona fide, arms-length sale in the event such other party has exercised a right of first refusal or similar right to purchase such Investment from Seller (the Parties shall agree separately in writing as to an appropriate reduction

relating to any Joint Venture that is not transferred to Buyer or Buyer's designee at Closing); and *minus*

(ix) Asbestos abatement liability as determined within five business days of the Closing by an independent third party mutually agreed upon by Seller and Buyer, *provided* that the total asbestos abatement liability shall not exceed $1,000,000.

(b) Notwithstanding the foregoing Section 2.05(a), no liabilities of Seller or its Affiliates shall be subtracted from the Purchase Price to the extent any such liabilities are already included in Net Working Capital.

(c) As further described in Sections 2.05(d) and 2.05(e) below, the Purchase Price will be calculated by Buyer and Seller at Closing from the physical count of inventory and supplies conducted pursuant to Section 2.05(d), if available, the relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available) and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. At Closing, Buyer shall pay such Purchase Price by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use whatever portion of the Purchase Price is necessary to defease the Bond Liabilities and to pay off all other indebtedness of Seller (other than capitalized leases assumed by Buyer).

(d) The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five business days before the Closing Date. Seller shall give Buyer at least five business days prior notice of the date of the count and permit Buyer to monitor the count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, quality and quantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then for purposes of the Closing, the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets.

(e) The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer. No more than five business days before the Closing Date, Buyer and Seller will agree on the value as of Closing of the prepaid expenses and deposits that Buyer reasonably determines will be usable after Closing.

(f) Within 90 days after the Closing Date, Buyer will deliver to Seller the Closing Balance Sheets together with any proposed revisions in the amount of the prorations to be made pursuant to Section 2.06 (based on paid invoices delivered by Buyer to Seller after the Closing). Except as otherwise provided herein, the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable and doubtful accounts, as used in preparing the Interim Closing Balance Sheets. The Purchase Price will be recalculated (based on clauses (i) and (ii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, and (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(e) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) on the Interim Closing Balance Sheets and on the Closing Balance Sheets. Following the resolution of any disputes pursuant to Section 2.05(g), Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Seller (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five business days after its determination.

(g) Should Seller disagree with the Closing Balance Sheets prepared by Buyer, it shall notify Buyer within 30 days after Buyer's delivery of the Closing Balance Sheets; if no notice shall be delivered by Seller to Buyer within such 30 day period, Seller will be deemed to have agreed with the Closing Balance Sheets prepared by Buyer. If Seller disputes any entry in the Closing Balance Sheets relevant to the calculation of the Purchase Price Adjustment or disputes the value of the inventory and supplies, then Buyer and Seller shall, for 15 days after Seller notifies Buyer of its dispute, attempt to resolve such dispute among themselves and to their mutual satisfaction. If Buyer and Seller are unable to resolve such dispute within such 15 day period, then either Seller or Buyer may submit the dispute to PricewaterhouseCoopers LLP or to such other independent, certified public accounting firm as Seller and Buyer may then agree in writing, in either case acting as experts and not as arbitrators to resolve the computation or verification of the disputed Closing Balance Sheets entries in accordance with this Agreement and otherwise where applicable in accordance with GAAP consistently applied.

(h) Seller and Buyer will each pay their own respective fees and expenses (including any fees and expenses of their accountants and other representatives) in connection with the resolution of disputes pursuant to this Section 2.05. Notwithstanding the foregoing, the fees and expenses of any accounting firm incurred in connection with the resolution of such disputes will be paid by Seller and Buyer in proportion to the

difference between the Purchase Price Adjustment determined by the accounting firm and the respective amounts of the Purchase Price Adjustment asserted by each such party at the time of the initial referral of the dispute to the accounting firm.

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer upon Buyer's receipt of such credit.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-stock corporation duly organized and validly existing in good standing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of any liabilities of Seller (other than Excluded Liabilities to be satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) do not violate any Legal Requirement to which Seller, the Assets, or the Hospital Businesses may be subject other than with respect to the Excluded Liabilities to be satisfied as of the Closing Date; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a breach or violation of any material Contract to which Seller is a party or by which it is bound and will not be terminated as of the Closing Date.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Subsidiaries and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its consolidated Subsidiaries, has total assets of $10,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of equity interests owned by Seller or its Affiliate in such Joint Venture and the name of, and percentage of equity interests owned by, third parties in such Joint Venture. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material assets, or any interest therein, of Seller, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Tenet or Buyer with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance. Except as otherwise provided in this Agreement and other than as set forth on Schedule 3.05, Seller and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material respects with, all Legal Requirements, and Seller has timely filed all material reports, data and other information required to be filed with Governmental Authorities. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor any Affiliate of Seller is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of Seller and the Hospital Businesses as of the respective dates thereof and for the periods therein referred to, all in accordance with GAAP, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, which are not, individually or in the aggregate, expected to result in a Material Adverse Change.

3.08. Recent Activities. Since September 30, 2013 and except as set forth on Schedule 3.08:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of the Hospital Businesses or as set forth on Schedule 3.08(b), consistent with past practice and existing personnel policies of Seller, Seller has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute, enactment or promulgation of a state or local Legal Requirement, or other event or condition, has occurred that has materially adversely affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) other than as set forth on Schedule 3.08(d), Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and Seller has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of $25,000, with a comparable replacement thereof;

(e) to Seller's knowledge, no Encumbrance has been imposed on any of the Assets;

(f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) other than in connection with the freeze of Seller's defined benefit pension plan and Post-Retiree Health Plan, there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment or ordinary course professional services agreements disclosed to Buyer, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of Seller or its Affiliates, or with any Affiliate of any such Person;

(i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Requirement excluding routine workers' compensation claims in amounts no greater than $100,000;

(j) Other than ordinary course plan benefit design changes, Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements and the freeze of Seller's defined benefit pension plan and Post-Retiree Health Plan;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in bona fide commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Schedule 3.10 includes a depreciation schedule as of a recent date that lists all items of equipment associated with, or constituting any part of, the Assets. To Seller's knowledge, and excluding information technology equipment and systems, all major items of Seller's equipment (e.g., heating systems, magnetic resonance imaging units, ultrasound units, robotic surgery and similar equipment) are usable for their intended purposes in the ordinary course of the Hospital Business and are in working condition, subject to reasonable wear and tear.

3.11. Title. Except as provided in Schedule 3.11 and subject to Section 10.03, Seller owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11. At Closing, Seller will convey to

Buyer good and valid title to all Assets, free and clear of any Encumbrances other than the Permitted Encumbrances.

3.12. Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a). The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and marketable fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) Seller has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) Except as set forth on Schedule 3.12(c), to Seller's knowledge, the buildings standing on the Owned Real Property are structurally sound and in need of no material maintenance or repairs, except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property, and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. To Seller's knowledge, no part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) Except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.18, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person other than in connection with financing. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and, to Seller's knowledge, Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all material Permits and requisite certificates of the local board of fire underwriters (or other material body

exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) (i) Seller has provided to Buyer accurate and complete copies of those leases of which Seller or one of its Subsidiaries is landlord (collectively, the "Space Leases"), and (ii) attached as Schedule 3.12(g) is a "rent roll" that sets forth the following information, if any, for each of the Space Leases: (A) the names of the current tenants; (B) the rental payments for the then current month under each of the Space Leases; (C) a list of all then delinquent rental payments; (D) a list of all outstanding concessions granted to tenants; (E) a list of all tenant deposits and a description of any application thereof; (F) the dates that each of the Space Leases commenced and will expire; (G) the square footage of any such space leased pursuant to the Space Leases; (H) any renewal options available to tenants under the Space Leases; and (I) a list of all uncured material defaults under the Space Leases known to Seller.

(h) There are no tenants or other Persons occupying any space in the Owned Real Property, other than pursuant to the Space Leases.

(i) Seller has (A) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(i) pursuant to the leases described on Schedule 2.01(b) (the **"Tenant Leases"**), and (B) provided accurate and complete copies of each of the Tenant Leases to Buyer. The Leased Real Property comprises all of the real property leased by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all material Permits required under applicable Environmental Laws for the operation of the Hospital Businesses, and all such Permits are listed on Schedule 2.01(g). Other than as listed on Schedule 3.13(a), no Environmental Claim is pending, or to Seller's knowledge, threatened by any Person against Seller or, to Seller's knowledge, any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where Seller stores, disposes or arranges for the disposal of material quantities or volumes of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real

Property are identified on Schedule 3.13(b) and (iv) to Seller's knowledge, no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations, claims of infringement or other Encumbrances, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in Section 3.18(c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). Seller has provided to Buyer a true and complete copy of all such policies and endorsements thereto. With respect to third party insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. Except as set forth on Schedule 3.15, all of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since September 30, 2010, Seller has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage provided thereby. Except as set forth on Schedule 3.15, since September 30, 2010, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. Each Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately

licensed are duly licensed by the appropriate Governmental Authorities. The Hospitals and all departments or business units, including the Hospital Businesses, comply in all material respects with the applicable licensing requirements. Each Hospital has complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.17. Government Payment Programs; Accreditation. Each Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. Each Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, except as reflected in the Audited Financial Statements, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through September 30, 2012, and Cost Reports have been audited and notices of program reimbursement have been issued for all Cost Report periods through September 30, 2010. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of each Hospital under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, neither Hospital has to its knowledge received nor submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or each Hospital's participation therein that remains outstanding or unresolved. All Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by Seller under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Seller or its Affiliates, and no such incentive payments were remitted due to any knowingly fraudulent, negligent or unlawful act or omission of Seller or its Affiliates. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made materially in the form and manner required by CMS and The Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. Each Hospital is duly accredited, with no contingencies except as disclosed on Schedule 3.17, by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to each Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of

correction since September 30, 2010. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. Schedule 3.17 includes a list and description of all unexpected occurrences involving death or serious physical or psychological injury since September 30, 2010.

3.18. Agreements and Commitments. Schedule 3.18 identifies the Contracts related to the Hospital Businesses in the categories below:

(a) Contracts that relate to the ownership or use of, title to or interest in Owned Real Property or Leased Real Property;

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospitals or (iii) any Person that provides marketing services for Seller or its Subsidiaries;

(c) Contracts relating to Intellectual Properties and Information Systems;

(d) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;

(e) Contracts with directors, trustees, officers, employees, or other agents of Seller or its Subsidiaries;

(f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;

(g) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between Seller and any of the Joint Ventures;

(j) Contracts with Governmental Authorities;

(k) Contracts providing for payments based in any manner on the revenue or profits of Seller or any Subsidiary thereof, the Hospital Businesses or the Assets;

(l) loan agreements, indentures, bonds, mortgages, liens, or other security agreements (excluding those that will be terminated at Closing);

(m) equipment leases and other leases that are capital leases; and

(n) all other Contracts which require payment by Seller of amounts in excess of $50,000 annually after the date of this Agreement, unless Seller may terminate the Contract, without cause, within ninety (90) days and all payments due by Seller under the

Contract through such termination equal, in the aggregate, less than $50,000 (including any penalty or termination fee).

3.19. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f):

(a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and, to Seller's knowledge, each other party thereto and are enforceable against Seller and, to Seller's knowledge, against each other party thereto, in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement between the parties thereto;

(c) all material obligations required to be performed under the Assumed Contracts by Seller, and, to Seller's knowledge, each other party thereto, have been performed, and no event has occurred or failed to occur that constitutes, or with the giving of notice, the lapse of time or both would constitute, a material default by Seller under the Assumed Contracts that has or would reasonably be expected to have a material impact on the Hospital Businesses;

(d) except as set forth on Schedule 3.19(d), no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing; and

(e) except as set forth on Schedule 3.19(e), the assignment of any Assumed Contract to, and assumption of such Assumed Contract by, Buyer will not give a third party the right to terminate such Assumed Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Except as disclosed in the Financial Statements of the Seller, since September 30, 2012, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller except upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii)

a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) To Seller's knowledge, all employees, former employees and independent contractors of Seller and its Subsidiaries are properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state Legal Requirement.

(c) Except as set forth in Schedule 3.21(c), Seller is in compliance in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; Seller is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.21(d) states the number of employees terminated by Seller and its Affiliates within 90 days prior to the Closing Date, laid off by Seller within the six months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Seller in the six months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours and (ii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.21(d), Seller has not violated the WARN Act or any similar state or local Legal Requirements.

(e) To the knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of Seller in respect of the Hospital Businesses or the Assets; or (ii) to assign to Seller any rights to any invention, improvement, or discovery. Except as set forth on Schedule 3.21(e), to the knowledge of Seller, no former or current employee of Seller is a party to, or is otherwise bound by, any contract that in any way adversely

affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as Seller did prior to Closing.

(f) Except as set forth on Schedule 3.21(f), (i) no employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to Seller's knowledge, threatened, (ii) no employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place and (iii) no complaint, charge or claim is pending, or, to Seller's knowledge, threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(g) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the knowledge of Seller, no employee of Seller who is a foreign national has ever worked for Seller without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and Seller has complied in all material respects with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To the knowledge of Seller, Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with Legal Requirements relating to immigration, except as set forth on Schedule 3.21(g). Seller has not received any letters or other correspondence from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and Seller has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of Seller. Seller does not participate in the Department of Homeland Security's e-Verify electronic employment verification system.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals) (each, a "**Current Seller Plan**").

(b) Each Current Seller Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current Seller Plan and applicable Legal Requirements.

All required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan. Seller has delivered to Buyer copies of the plan documents and summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller has maintained, or to which it has contributed or been required to contribute (each, a "**Prior Seller Plan**"), during the five (5) years preceding the date of this Agreement, and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) to each such Employee Pension Benefit Plan that are due to be paid have been paid, and all Seller contributions to any Employee Pension Benefit Plan that is a defined contribution plan in respect of periods ending on the Closing Date will be accrued on the Closing Balance Sheets. To Seller's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal Revenue Service, as applicable. To Seller's knowledge, nothing has occurred with respect to any Current Seller Plan that has subjected or could reasonably be expected to subject Seller, or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a penalty under Section 502 of ERISA or to an excise tax under the Code. To Seller's knowledge, with respect to any Current Seller Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject the Seller or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a tax under Section 4971 of the Code or the assets of any of the foregoing persons to a lien under Section 430(k) of the Code.

(d) The requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met in all material respects with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments that are due have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any material liability. No ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of

the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or, to Seller's knowledge, threatened and, to Seller's knowledge, there exists no basis for any such Proceeding. To Seller's knowledge, no "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Benefit Pension Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.22(f), no Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or, to Seller's knowledge, threatened. Seller has not incurred, and, to Seller's knowledge, Seller will not incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) Neither Seller nor any member of a Controlled Group that includes Seller contributes to, has contributed to, or has been required to contribute to any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan. Except as provided on Schedule 3.22(g), neither Seller nor any member of a Controlled Group that includes Seller maintains or contributes, has maintained or contributed, or has been required to maintain or contribute to any Employee Welfare Benefit Plan providing medical, health or life insurance or other welfare-type benefits for current or future retired or terminated employees, their spouses or their dependents (other than in accordance with section 4980B of the Code).

3.23. Proceedings and Legal Claims. Schedule 3.23 contains a list and summary description of each Proceeding and legal claim (including *qui tam* Proceedings and legal claims) pending or, to Seller's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, Seller or any Affiliate of Seller (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or legal claim). All such Proceedings and legal claims are or will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. None of the Proceedings or legal claims described on Schedule 3.23, if determined adverse to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Seller has filed all Tax Returns required to be filed by or on behalf of Seller on or prior to the date of this Agreement (taking into account applicable extensions), all such Tax Returns are accurate in all material respects and Seller has duly

paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of Seller, threatened. There are no outstanding agreements by Seller for the extension of time for the assessment of any Taxes (other than ordinary course extensions of time within which to file Tax Returns).

(d) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has ever been made in writing by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction, and no Encumbrances exist against Seller or the Assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to Seller (other than ordinary course extensions of time within which to file Tax Returns).

(f) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of Seller and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service and the State of Connecticut regarding such Tax status and, to Seller's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption (except with respect to the transactions contemplated by this Agreement).

(h) To Seller's knowledge, Seller has no liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations.

(a) Seller has delivered to Buyer a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of each Hospital. As

set forth on Schedule 3.25(a), Seller has also delivered to Buyer a list, current as of the date of this Agreement, that sets forth (i) the name and age of each member of the medical staff of each Hospital (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each such medical staff member, (iii) the names of the medical staff members (current and former) of each Hospital in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members of each Hospital in respect of whom any committee of the medical staff of such Hospital has recommended adverse action with respect to any member of the medical staff of such Hospital that is not yet final.

(b) Except as set forth on Schedule 3.25(b), no material disputes between Seller and any medical staff member of either Hospital are pending or, to Seller's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. To the knowledge of Seller, no current member of the medical staff of either Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any restriction or limitation concerning the purchase, improvement or use of such Assets or the conduct of the Hospital Businesses, including restricted or conditioned grants or donations and monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. None of the Hospital Businesses has, to Seller's knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor, to Seller's knowledge, any officer, director or trustee of Seller has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Hospital Businesses and Joint Ventures.

(a) Each of Seller's Subsidiaries is a corporation duly organized under the laws of the State of Connecticut with full corporate power to carry on its business as it is now being conducted with the exception of Connecticut Health Insurance Company, which is organized with full corporate power to carry on its business as it is now being conducted under the laws of the Cayman Islands. Each of Seller's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations are owned as specified on Schedule 3.30(a). All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of Seller's Subsidiaries that are stock corporations and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of Seller's Subsidiaries and has provided to Buyer a copy of, or access to, the minute books of Seller's Subsidiaries.

(b) To Seller's knowledge, for each Joint Venture that is a for-profit or nonprofit corporation, it (i) is a corporation duly organized under the laws of the state of its incorporation, (ii) has full corporate power to carry on its business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations are owned as specified on Schedule 3.30(b). To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, there are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of the corporate Joint Ventures and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of the corporate Joint Ventures in Seller's possession.

(c) To Seller's knowledge, for each Joint Venture that is a limited liability company, it (i) is organized under the laws of the state of its incorporation, (ii) has full limited liability company power to carry on its respective business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good

standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding membership interests of the limited liability company Joint Ventures are owned as specified on Schedule 3.30(c), have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, except as set forth in the operating agreements of the limited liability company Joint Ventures, the transfers to Buyer of the membership interests in the limited liability company Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer a copy of the articles of organization and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the limited liability company Joint Ventures in Seller's possession.

3.31. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in the manner in which they have been operated since September 30, 2013, except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.31 sets forth a list of the ten largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the year ended September 30, 2013. Since September 30, 2012, no payor listed on Schedule 3.31 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

3.32. Full Disclosure. To Seller's knowledge, the representations of Seller in this Agreement and the Closing Documents do not contain any untrue statement of a material fact or, when read in the aggregate, fail to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading. Seller has provided or made available to Buyer all material documents and information that has been requested by Buyer or its representatives.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization. Buyer is a limited liability company duly organized and validly existing and in good standing under the laws of the State of Delaware. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

4.02. Power and Authority; Due Authorization. Buyer has full power and authority to (a) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (b) perform its obligations under this Agreement and such Closing Documents and (c) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary limited liability company action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within its limited liability company powers, are not in contravention of its certificate of formation and operating agreement and have been approved by all required limited liability company and member action;

(b) do not violate any Legal Requirement to which it is subject; and

(c) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer will be a party will constitute (upon execution and delivery thereof by Buyer at the Closing), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the terms hereof and thereof.

4.05. Proceedings. There are no claims, actions, suits, proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, or (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder.

4.06. Availability of Funds. Buyer has the ability to obtain funds in cash in amounts equal to the Purchase Price and necessary to perform its obligations hereunder that are to be performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform its obligations hereunder that are required to be performed as of Closing under this Agreement.

4.07. Solvency. Buyer has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of

Buyer's property and, to the knowledge of Buyer, no other Person has filed or threatened to file such a petition against Buyer.

4.08. Brokers and Finders. Neither Buyer nor any Affiliate of Buyer, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.09. Full Disclosure. The representations of Buyer in this Agreement do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

4.10. Strategic Affiliation. Tenet and Yale-New Haven Health Services Corporation ("**YNHHSC**") have entered into a strategic affiliation, including a definitive agreement between Tenet and YNHHSC, and such agreement and any operating agreements required by such agreement will be in full force and effect as of Closing. A true and complete copy of such agreements has been delivered to the Seller.

5. COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates to:

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses except as set forth on Schedule 5.01;

(b) except as set forth on Schedule 5.01(b), maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that Seller may (i) make, in its discretion, necessary expenditures in the ordinary course from its designated capital needs fund and provide advance notice to Buyer of any individual expenditure greater than $100,000 and (ii) consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) not paid from its designated capital needs fund that exceed $100,000;

(c) comply in all material respects with all Legal Requirements and perform, when due, in all material respects all obligations under Contracts;

(d) deliver to Buyer title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances) and to obtain appropriate releases, consents, estoppels, certificates, opinions and other instruments as Buyer may reasonably request;

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain

sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) maintain and preserve its business organizations and operations intact, retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course of the Hospital Businesses), and maintain in the ordinary course its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate to:

(a) excluding capital expenditures, amend or terminate any Assumed Contract, or enter into any Contract, except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall obtain Buyer's consent on any new Contract (or a series of related Contracts) that has required payments by Seller that exceed $100,000 annually, unless such Contract may be terminated without cause upon no more than 90 days written notice and such termination will not result in any penalty or fee (and excluding any waivers or amendments relating to Bond Liabilities that will be defeased or repaid at Closing);

(b) enter into any tertiary or quaternary affiliation with a third-party healthcare provider other than an agreement for hospitalist services;

(c) other than as set forth on Schedule 5.02(c), increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee, contractor or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets;

(e) sell or otherwise transfer or dispose of any item of property, plant, equipment or other Asset except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof;

(f) distribute any assets, other than Excluded Assets, to any Affiliate of Seller other than its Subsidiaries that are transferring Assets pursuant to this Agreement;

(g) make necessary expenditures in the ordinary course from its designated capital needs fund of more than $100,000 per expenditure without providing advanced notice to Buyer of such expenditure and will not make individual capital expenditures (or a series of related capital expenditures) that are outside the ordinary course in excess of $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual operating or capital budgets that have been provided to Buyer;

(h) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses other than entering into an agreement with a third party for the provision of hospitalist services, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided without consent of Buyer, which will not be unreasonably withheld or delayed;

(i) create, incur, assume, guarantee or otherwise become liable for any liability or obligation except in the ordinary course of the Hospital Businesses consistent with past practices in excess of $250,000, other than Seller's customary annual line of credit renewal with TD Bank in the currently issued amount, or agree to do any of the foregoing;

(j) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations in respect of Accounts Receivable or other Assets, or agree to do any of the foregoing, except in the ordinary course of the Hospital Businesses consistent with past practices;

(k) amend, change or modify the title or duties of the chief executive officer of Seller;

(l) sell or factor any Accounts Receivable;

(m) change any accounting method other than as needed for purposes of the previously planned freeze of Seller's defined benefit pension plan and Post-Retiree Health Plan, policy or practice or reduce any reserves in the Financial Statements except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business consistent with past practices and (ii) changes required by GAAP or applicable Legal Requirements;

(n) except with respect to the previously planned freeze of Seller's defined benefit pension plan and Post-Retiree Health Plan, terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for normal course annual changes and amendments required to comply with this Agreement or applicable Legal Requirements;

(o) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of Seller or any Subsidiary thereof or otherwise take any action relating to any liquidation or dissolution of Seller or any Subsidiary thereof, except as expressly contemplated by this Agreement, provided that Seller may merge any one or more of the Subsidiaries into each other or into the Seller in connection with the proposed transaction;

(p) amend or agree to amend the governing documents of any Joint Venture, except immaterial amendments or amendments required to comply with applicable Legal Requirements or reasonably necessary to assign and transfer to Buyer or Buyer's designee Seller's Investment in, or for Buyer to become a partner, member or shareholder

of, such Joint Venture or to restructure such Joint Venture as to permit the Buyer to participate in such Joint Venture; or

(q) take any action outside the ordinary course of the Hospital Businesses other than modifying its Bond documents as needed.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this Section and in reliance upon the representations of Seller in Sections 3.21 and 3.22, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date substantially all employees of Seller and its Affiliates who work at the Hospital Businesses, including but not limited to employees on approved leaves of absence as of the Closing Date for any reason including without limitation by reason of a military leave, family or medical leave, illness, injury, disability or similar situation (provided employment shall not commence until such employees return from such approved leave), on the same terms and conditions with respect to job duties, titles and responsibilities that are applicable to such employees on the date of such offer. Buyer will offer the Hired Employees salaries equal to their salaries as of the Closing Date and Employee Benefit Plans that are consistent with Employee Benefit Plans offered to similarly-situated employees at other hospitals operated by Subsidiaries of Tenet in similar markets. Notwithstanding the foregoing, Buyer will, and will cause its Affiliates to, in all events provide each Hired Employee terms and conditions of employment, including compensation and employee benefits, sufficient to avoid Seller or its Affiliates from incurring any liability under the WARN Act or any comparable Legal Requirement due to actions or omissions of Buyer and its Affiliates related to the Hired Employees at any time on or after the Closing Date.

(b) Seller acknowledges that all employment offers are for "at will" employment only and are subject to the satisfactory completion by Buyer of Tenet's usual and customary hiring practices, including employee background checks and pre-employment screenings. Nothing in this Section or elsewhere in this Agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in Section 5.03(a) and (c), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, provided that Buyer will assume and honor all written severance agreements between Seller and Seller's employees existing as of Closing that are provided to Buyer prior to the date hereof, as set forth on Schedule 5.03(b).

(c) Following the Closing Date, each Employee Benefit Plan sponsored by Buyer or any Affiliate of Buyer in which the Hired Employees are eligible to participate shall credit the Hired Employees with their periods of employment with Seller or any Affiliate of Seller for all purposes (other than benefit accrual under any defined benefit pension plan), including, but not limited to, application of any preexisting condition limitation or eligibility period otherwise applicable to the Hired Employees and their eligible dependents. In addition, if prior to the Closing Date a Hired Employee or his or her covered dependents paid any amounts towards a deductible or out-of-pocket

maximum in Seller's medical and health plan's current fiscal year, such amounts shall be applied toward satisfaction of the deductible or out-of-pocket maximum in the current fiscal year of Buyer's medical and health plan that covers Hired Employees on and after the Closing Date. Buyer will give all Hired Employees credit for their vacation, holiday, personal time and sick pay (whether in such form or in the forms of so-called "paid time off" or an "extended illness bank") to the extent the same constitute Assumed Liabilities. With respect to the Hired Employees, Buyer will assume the Workers' Compensation Liability that exists as of Closing and any such claims filed on or after Closing with respect to periods prior to Closing. Except as provided in subsection (b) above, this subsection (c), subsection (e) below, or Schedule 2.03, or as otherwise required by Legal Requirements, Buyer will not assume or otherwise become liable for, and Seller will remain solely responsible for, (i) Seller's Employee Welfare Benefit Plans and (ii) any other obligations to former or currently retired employees or their dependents. Buyer will make available group health plan continuation coverage required under COBRA to employees and former employees of Seller who are eligible for COBRA, provided that, with respect to COBRA beneficiaries whose qualifying events occurred on or prior to the Closing Date, Seller will reimburse Buyer for all claims of such COBRA beneficiaries paid by Buyer and its Affiliates in excess of the sum of (A) COBRA premiums collected from the COBRA beneficiaries; and (B) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all such COBRA beneficiaries. Buyer agrees to accept rollovers of eligible rollover distributions (within the meaning of Code section 402(c)(4)), including to the extent applicable rollovers of any outstanding loans made as part of a direct rollover, made by Hired Employees from Seller's Employee Pension Benefit Plans to Buyer's Plans.

(d) Prior to Closing, Seller shall freeze its defined benefit pension plan known as the "Eastern Connecticut Health Network, Inc. Pension Plan amended and restated as of December 31, 2013" to new participation and future accruals and shall freeze the Post-Retiree Health Plan to new participation. With respect to the Post-Retiree Health Plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing. With respect to the Post-Retiree Health Plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing and shall not amend or terminate the Post-Retiree Health Plan unless the members of such group are provided another retiree medical benefit or cash payment of equivalent value (as calculated using reasonable assumptions determined in consultation with an actuary at the time of the determination).

(e) As of the Closing, Buyer agrees to assume, administer, and become the sponsor of Seller's defined benefit pension plan known as the "Eastern Connecticut Health Network, Inc. Pension Plan amended and restated as of December 31, 2013" and Seller's post-retiree health plan and assume all collective bargaining agreements of Seller that pertain to the Hospital Businesses.

(f) Between the date of this Agreement and Closing, Buyer may run newspaper advertisements, in the name of any of the Hospital Businesses or in the name

of Buyer, to recruit employees for the Hospital Businesses to commence on or after the Closing Date.

(g) At Closing, Seller shall deliver to Buyer a list setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this Agreement and the Closing Date.

(h) This Section 5.03 shall not apply to employees employed by Seller under Assumed Contracts, including but not limited to the collective bargaining agreements described in subsection (d) above. Buyer shall offer employment to all such employees, subject to the satisfactory completion by Buyer of Tenet's usual and customary hiring practices, including employee background checks and pre-employment screenings, and employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(i) On or prior to the Closing Date, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after the Closing Date, Buyer will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the Hired Employees, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets and books and records relating to the Hospital Businesses, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to Seller. Buyer shall exercise its rights under this Section 5.04(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses.

(b) Seller will deliver to Buyer:

(i) within 25 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within 35 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related

unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) Until the Closing Date, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by The Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense,

any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) To the extent Seller remains in existence and maintains sufficient operational control over relevant functions and pursuant to the Transitional Services Agreement, for seven years after the Closing Date, Seller will give Buyer, within 30 days after request, an updated claims history, including losses paid and open reserves, for all claims relating to the conduct of the Hospital Businesses on or before the Closing Date.

5.06. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authority to consummate the transactions contemplated by this Agreement, *provided* that no party may be required without the party's consent (x) to pay any sum to Governmental Authorities other than filing fees or past due amounts, or (y) to agree to divest assets or limit the conduct of its businesses.

(b) Until the Closing Date, each party shall file, if and to the extent required by applicable Legal Requirements, all reports and other documents required or requested by Governmental Authorities under the HSR Act concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the

Governmental Authorities for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the HSR Act and shall exchange drafts of the relevant portions of each other's report forms before filing. The parties shall also share equally the costs of any fees due in respect of filings required by the HSR Act.

(c) Seller shall promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, provided that Seller shall not be required to make any payments or economic concessions to landlords to obtain such consents.

(d) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller and a third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.07. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Affiliates, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

5.08. Connecticut Transfer Act. Certain components of the Real Property (including the Hospitals) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and

Buyer shall prepare an appropriate Transfer Act Form and accompanying ECAF for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees (which shall be reimbursed by Seller); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II Assessments subject to and in accordance with the provisions of Section 7.09 hereof. Buyer or its designee shall conduct and complete any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Form and the ECAF, to comply with the Transfer Act, and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Facilities have been remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer Act Activities**"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Notwithstanding the foregoing, Seller shall pay Buyer for all costs and expenses that Buyer incurs in connection with Transfer Act Activities. Seller and Buyer agree to execute and deliver all documents reasonably requested by the other to comply with the Transfer Act. All undefined terms in this Section 5.08 shall have the meanings set forth in the Transfer Act. Notwithstanding anything to the contrary in this Agreement, the Parties agree that any and all fees, expenses and other costs to be paid by Seller under this Section 5.08 shall be paid first from funds held as part of the Indemnity Reserve established pursuant to Section 9.08.

5.09. No-Shop Clause. Until termination of this Agreement, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or other disposition all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this Section.

5.10. Noncompetition. For a period of five years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses, including any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, wellness center, urgent care center, ambulatory service, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a 30 mile radius of either Hospital (the "**Restricted Area**"); (ii) employ or solicit the employment of any Hired Employee, other than no more than five (5) individuals employed solely for winding down operations, unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliate after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any contract for the provision or arrangement of health care services from the Hospital Businesses with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any contract with or change practice patterns at the Hospital Businesses. Notwithstanding the foregoing, however, (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospitals: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services to be provided by Buyer or its Affiliates. In the event of a breach of this Section, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Buyer and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

5.11. Allocation of Purchase Price. Within a reasonable time after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with section 1060 of the Code. Buyer's

proposed allocation will become final and binding on the parties 45 days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within 60 days after Seller gave its objection to Buyer. If a final resolution is not reached within 60 days after Seller has submitted its objection in writing, each of Buyer and Seller shall make their own independent allocation of the total consideration among the Hospital Businesses and the Assets. If Seller and Buyer reach agreement upon the allocation (or Seller does not object to Buyer's proposed allocation), Seller and Buyer will be bound by the agreed allocation and (for federal and state Tax purposes) account for and report the transactions contemplated by this Agreement in accordance with such allocation, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the Internal Revenue Service in accordance with such allocation.

5.12. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

5.13. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or materially damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Business is rendered unsuitable for its primary intended use and the cost of repair would exceed $1,000,000, Buyer may elect, by giving written notice to Seller within 15 business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 8.04(a), (ii) consummate the transaction in spite of such destruction or damage but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the

insurance proceeds less any reasonable out-of-pocket costs incurred in collecting the proceeds or in securing or repairing the property (or the right to receive the insurance proceeds) payable on account of such destruction or damage, and Buyer shall receive a credit for any deductibles or copayments required under the applicable insurance policy in respect of such claim. Notwithstanding the foregoing, Buyer and Seller acknowledge and agree that the Purchase Price shall not be reduced by an amount that would preclude Seller from paying, or providing for payment of, all of its liabilities in full.

5.14. Seller's Cost Reports. Pursuant to the Transitional Services Agreement, Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this Agreement. Buyer will provide information to Seller and reasonably assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in Section 5.11. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within ten business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any payables resulting from or reserves relating to the Cost Reports and the right to appeal any Medicare determinations relating to the Cost Reports.

5.15. Continuation of Hospitals and Post-Care Continuum. For at least three (3) years after Closing, Buyer will (i) continue operating the Hospitals in their current locations as acute care hospitals with emergency departments, and (ii) maintain an ownership interest in Seller's current post-acute care continuum of care network (e.g., VNA/home care, sub-acute and long-term lines of service) and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period. During such periods that Buyer operates the Hospitals, Buyer agrees to maintain Seller's commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs.

5.16. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided support for community volunteer services and care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that each Hospital maintains and adheres to Seller's current policies on charity care, indigent care, community volunteer services and community benefits attached as Schedule 5.16 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as Seller's existing policies.

(b) During all times that Buyer owns and operates the Hospitals, Buyer will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.17. Educational Support. Buyer agrees to maintain and support financially the University of New England medical student and other health professions teaching programs established by Seller, in addition to Seller's graduate medical education programs, while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by CMS.

5.18. Capital Commitment.

(a) Post-Closing, Buyer, in consultation with Seller, the Local Board and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses (which for purposes of this Section 5.18 includes the Joint Ventures). In accordance with such strategic capital plan, Buyer agrees to spend within five years of Closing or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) within five years of Closing not less than $75,000,000 (the "**Commitment Amount**") on (i) capital projects, including routine and non-routine capital expenditures for the improvement of Seller's facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services (such as implementation of a comprehensive and system-wide electronic medical record such as the Epic system), (ii) de novo development, expansion, or acquisition of a department, program, service or facility (whether for inpatient or outpatient services), (iii) upgrades or renovations generally, (iv) deferred maintenance items, and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. Buyer shall provide a written report to Seller on an annual basis that verifies its compliance with the capital commitment, which Seller may share publically. For the purposes of determining whether the Commitment Amount has been expended or committed to be expended, (x) only operating leases for (i) buildings or the fit-out or build-out of space used in the provision or support of medical services or (ii) medical equipment with a useful life of more than one year, shall count towards the Commitment Amount, (y) capital leases, and those operating leases that are permitted to be counted toward the Commitment Amount under Section 5.18(a)(x)(i)-(ii), shall be valued at the net present value of any lease commitments, and (z) solely with respect to expenditures for equipment not currently owned or leased by the Hospital Businesses or space that is renovated, acquired or newly leased (with respect to incremental Tenet improvements) obtained after Closing consistent with this Section 5.18, it shall not be a prerequisite that the applicable expenditure be classified as a capital expenditure for accounting purposes.

(b) Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed by the State of Connecticut after Closing that discriminates against, or adversely affects a disproportionate number of for-profit hospitals and causes the Hospital Businesses to suffer a decline in EBITDA of more than ten (10) percent in any year, on a consolidated basis, then, Buyer may defer in its discretion the above capital commitment beyond the five-year period provided in Section 5.18(a) but only to the extent of the decline in EBITDA resulting from the discriminatory Legal Requirement. To the extent Buyer desires to defer the capital commitment as a

result of a discriminatory Legal Requirement, (i) Buyer shall make available to the public reasonably detailed information to support Buyer's position (provided that in no event shall Buyer be required to disclose any information that is subject to a confidentiality or other similar arrangement) and (ii) Buyer shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

5.19. Connecticut Transactions. If at any time prior to Closing, Buyer or any of its Affiliates and YNHHSC collectively enter into an agreement with another Connecticut hospital that seeks to consummate transactions similar to the transactions described herein, then Buyer shall promptly inform Seller of such fact, subject to such hospital's approval of waiving any nondisclosure obligation in a confidentiality agreement between such hospital and Tenet (or an Affiliate thereof) or YNHHSC.

5.20. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller or its Affiliates shall bear and pay all expenses incurred by or on behalf of Seller in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising with or assessed to Seller or its applicable Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 7.06.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the

Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

5.21. Clinical Quality and Integration. For at least three (3) years after Closing, Buyer shall (i) collaborate with the Local Board and remaining former hospital staff of Seller on clinical quality matters of the Hospital Businesses to share best practices, establish clinical quality goals and measure progress, and (ii) to the extent consistent with antitrust Legal Requirements, consult with physicians on the medical staff of each Hospital, including at least some independent (*i.e.*, non-employed) physicians, in managed care contracting and clinical integration with respect to the Hospital Businesses.

5.22. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so or as is otherwise required to do so by Legal Requirements.

5.23. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

5.24. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.25. Insurance Transition Provisions.

(a) With respect to the Disability Obligations, Buyer and Seller acknowledge and agree that no tail insurance shall be required in connection with the Disability Obligations because Seller is fully insured with respect to the Disability Obligations.

(b) Other than with respect to the Accumulated Benefit Obligation, the Post-Retiree Health Plan Liability, the Captive Insurer Liability and the Workers' Compensation Liability, on or before the Closing Date, Seller will purchase and obtain an unlimited extended claims reporting provision for all primary and excess insurance policies, including but not limited to coverage for directors, trustees and officers of Seller and its Affiliates, in force as of the date of this Agreement that cover Seller, its Affiliates and each physician employee of Seller or its Affiliates (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder.

(c) Notwithstanding anything in this Agreement to the contrary and to the extent in the best interests of Seller, Seller may choose in its sole discretion to retain the Captive Insurer Liability, the Workers' Compensation Liability or both and, at or prior to Closing, purchase its own tail insurance policy or policies with respect to the Captive Insurer Liability, the Workers' Compensation Liability or both. To the extent Seller elects to retain the Captive Insurer Liability, the Workers' Compensation Liability or both, Seller shall provide written notice to Buyer of such election, and Buyer will be relieved of its obligations set forth in this Agreement with respect to any liability or liabilities that Seller elects to retain as set forth in such written notice, and there shall be no reduction in the Purchase Price pursuant to Section 2.05(a)(vi)-2.05(a)(vii)for any liabilities so retained.

5.26. Strategic Business Plan. After Closing, Buyer will use commercially reasonable efforts to execute and implement the Strategic Business Plan in accordance with its terms, as the Strategic Business Plan may be modified by Buyer, in consultation with the Local Board, from time to time.

5.27. Local Board. The Local Board shall, among other things, serve as a resource for Buyer with respect to Buyer's investment of the Capital Commitment (see Section 5.18 herein), maintenance and implementation of the Strategic Business Plan, be responsible for medical staff credentialing at the Hospitals, maintain and oversee the quality assurance program at the Hospitals and oversee and manage the accreditation process for the Hospitals.

5.28. Compliance Program. The Buyer and its Affiliates have established and implemented corporate compliance and ethics programs to ensure that high ethical and conduct standards are met in the conduct of their business. Buyer shall extend after Closing its corporate compliance and ethics programs to the Hospital Businesses.

5.29. Connecticut Strategy. Buyer, as part of the strategic affiliation between Tenet and YNHHSC, shall provide to the Hospital Businesses after Closing the expertise of YNHHS in connection with service line development and clinical operations. Buyer shall also engage in branding activity with respect to the Hospital Businesses after Closing that will designate the Hospitals and the Assets, as appropriate, as affiliated with YNHHSC, as agreed between YNHHSC and Buyer.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Buyer was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct

on and as of the Closing Date, and each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authorizations of Governmental Authorities, including (i) the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, (ii) confirmation that the Bond Liabilities have been satisfied, and (iii) approval for the conversion of the Hospitals to a for-profit entity by the Attorney General (including receipt of a fairness evaluation or fairness opinion satisfactory to the Seller and the Attorney General) and approval of the transfer or disposition of all donor restricted funds of the Hospitals and all Subsidiaries in a manner acceptable to the Attorney General, required for Seller to consummate the transactions contemplated by this Agreement and that all applicable waiting periods under the HSR Act shall have expired or been terminated.

6.04. Redemption of the Bonds/Satisfaction of the Indenture. All actions required to be taken and all conditions required to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, including the Bond Liabilities, and the satisfaction, discharge, release, and termination of all trust indentures, tax-exempt equipment loans and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have been, or at Closing will be, taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from counsel to the Connecticut Health and Education Facilities Authority to the effect that all Bond Liabilities have been defeased or prepaid, together with evidence satisfactory to Buyer of the discharge of all Encumbrances on the Assets under the Indenture.

6.05. Extraordinary Events. Buyer (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United

States or any state (and no such petition has been filed against Buyer), or (f) has not entered into any contract to do any of the foregoing on or after the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Seller in this Agreement is true and correct in all material respects on and as of the Closing Date (other than the representation in Section 3.08(l) which shall be true and correct in all respects).

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of Seller's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by Seller, and approved by Buyer, all in accordance with Section 10.01.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

7.03. Material Adverse Change. Since the date hereof, no Material Adverse Change has occurred and no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Change.

7.04. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) All Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any

condition that is materially burdensome to the operation of the Hospital Businesses after Closing;

(b) The applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospitals, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) All other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospitals to a for-profit entity by the Attorney General, required for Buyer to consummate the transactions contemplated by this Agreement and all other material consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to operate the Hospital Businesses after Closing shall have been received;

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts, and certain other consents, waivers and estoppels, that are listed on Schedule 7.04(d);

(e) Seller has obtained approvals from its Board of Trustees, corporators and, to the extent required, the governing boards of its Subsidiaries; and

(f) All applicable waiting periods under the HSR Act have expired or been terminated.

7.05. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.06. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a recognized national title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably acceptable to Buyer and with such endorsements as Buyer may reasonably require, at Buyer's sole cost and expense; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company, at Buyer's sole cost and expense.

7.07. Opinion of Seller's Counsel. Buyer has received an opinion from counsel to Seller, dated as of the Closing Date and addressed to Buyer, in a form reasonably satisfactory to Buyer.

7.08. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture, specifically the Bond Liabilities and other tax-exempt debt, shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in Section 6.04.

7.09. Environmental Assessments. Buyer shall have received a Phase I environmental site assessment in a form reasonably satisfactory to Buyer, on each parcel of Owned Real Property and, at Buyer's option, any portion of the premises forming a part of the Leased Real Property (each, a "Phase I Assessment," collectively, the "Phase I Assessments"). Buyer shall not be permitted to conduct any Phase II environmental site assessments, or other intrusive or destructive testing on or relating to the Owned Real Property or Leased Real Property (each, a "Phase II Assessment," collectively, the "Phase II Assessments") unless pursuant to information contained in the applicable Phase I Assessment and subject to the prior approval of Seller (including any conditions which Seller may impose on such investigations, and, if Seller so requires, memorialized in an environmental access agreement between Buyer and Seller), in Seller's sole discretion. Notwithstanding the foregoing, if, after review of any Phase I Assessment, the parties reasonably determine that the subject real property is an Establishment Real Property (as defined in Section 5.08 hereof) and reasonably identifies any "areas of concern" ("AOCs") warranting additional investigation pursuant to the Transfer Act, then, in order to obtain a preliminary (but not definitive) understanding of the nature and extent of any contamination potentially associated with such AOC, Buyer shall have the right to perform a limited Phase II Assessment of each such AOC pursuant to a scope of work approved by Seller in advance, which approval (including any conditions which Seller may reasonably impose on such investigation) shall not be unreasonably withheld, conditioned or delayed. Buyer shall pay the first $50,000 of the aggregate costs of the Phase I Assessments and any Phase II Assessments that may occur pursuant to this Section 7.09. If the aggregate costs of the Phase I Assessments and any Phase II Assessments obtained pursuant to this Section 7.09 exceed $50,000, such additional costs shall be paid 50% by Buyer and 50% by Seller. Notwithstanding any other provision hereof to the contrary, Buyer shall not provide Seller with copies of any Phase II Assessment (or any of the data contained therein) unless requested by Seller. To the extent any Phase II Assessments are performed in accordance with this provision, Buyer shall be reasonably satisfied with same.

7.10. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.11. Physician Alignment. Tenet shall have caused a medical foundation (the "**Foundation**") to be formed in the State of Connecticut. Tenet or an Affiliate thereof will be the sole member of the Foundation, which will employ licensed physicians and other licensed

"Providers," as defined in Section 33-182aa of the Connecticut General Statutes, including those licensed physicians and other licensed Providers employed by Seller or its Affiliates immediately prior to the Closing Date.

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at [_____] at 10:00 a.m., or at such other place and time as the parties may mutually agree, on _____, 2015, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, Tenet.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Assets.

8.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

(e) limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit B attached hereto, fully executed by Seller;

(f) an original or certified copy of the tail insurance policies required by Section 5.25 and receipts evidencing payment of the premiums therefor;

(g) a copy of resolutions duly adopted by the board of directors of Seller authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of Seller;

(h) a certificate of a duly authorized officer of Seller certifying that (i) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(i) a certificate of incumbency for the officers of Seller executing this Agreement and the Closing Documents;

(j) a certificate of existence and good standing for Seller and each of its Subsidiaries from the State of Connecticut, dated no earlier than 15 days prior to the Closing Date;

(k) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Joint Ventures, duly endorsed for transfer to Buyer, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer;

(l) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of Seller or any Affiliate conveying an interest in Owned Real Property to Buyer or its Affiliates, certifying that such entity is not a foreign corporation and is not otherwise a foreign Person;

(m) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets, including for all motor vehicles;

(n) all necessary state and local real estate conveyance tax forms duly executed by Seller;

(o) final execution copy of the Transfer Act Form III and ECAF with a $3,000 filing fee, as more fully described in Section 5.08;

(p) UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing;

(q) the opinion of counsel to Seller as provided in Section 7.07;

(r) owner's affidavits, certificates, rent rolls and other documentation that may be reasonably necessary to consummate the transactions contemplated by this Agreement and obtain the title policies required to be issued hereunder;

(s) the Transitional Services Agreement, fully executed by Seller; and

(t) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) The Purchase Price due to Seller, as adjusted in accordance with Section 2.05;

(b) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities, as well as any documents Seller may reasonably require to effectuate Buyer's assumption of certain of Seller's Employee Benefit Plans pursuant to Section 5.03(e);

(c) a copy of resolutions duly adopted by the boards of directors, members or managers of Tenet and Buyer, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of Tenet and Buyer;

(d) a certificate of a duly authorized officer of Buyer certifying that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of Buyer in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this Agreement is true and correct in all

material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(e) a certificate of incumbency for the officers of Tenet and Buyer executing this Agreement and the Closing Documents;

(f) a certificate of existence and good standing of Buyer from the State of Delaware, dated no earlier than 15 days prior to the Closing Date;

(g) the Transitional Services Agreement, fully executed by Buyer; and

(h) such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Article 7; (iii) by Seller, by written notice to Buyer if any event occurs or condition exists which causes Buyer to be unable to satisfy one or more conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Article 6; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before May 1, 2015 (as such date may be extended by mutual agreement of Seller and Buyer); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; or (v) by Buyer, pursuant to Section 5.13 or Section 10.01 hereof.

(b) In the event that this Agreement is terminated by Buyer or Seller (the "**Terminating Party**") because the other party (the "**Breaching Party**") refuses to close the transactions contemplated by this Agreement in violation of Section 5.23 when the Terminating Party is in compliance in all material respects with the terms of this Agreement, then the Breaching Party shall, within five business days after receipt of written notice of such termination, pay to the Terminating Party by wire transfer of immediately available funds to an account designated by the Terminating Party a fee equal to $3,150,000 (the "**Termination Fee**"). The parties acknowledge and agree that the agreements contained in this Section are an integral part of the transactions contemplated by this Agreement and constitute liquidated damages and not a penalty. If the Breaching Party fails to pay the Termination Fee in accordance with the terms of this Section 8.04(b), then the Breaching Party shall pay the costs and expenses (including legal fees and expenses) of the Terminating Party in connection with any action, including the filing of any lawsuit or other legal action, taken to collect payment, together with interest as provided in Section 10.20 from the date such Termination Fee was

required to be paid. Notwithstanding anything to the contrary in this Agreement, the Terminating Party's right to receive payment of the Termination Fee pursuant to this Section 8.04(b), and the right to receive the payment of its costs and expenses as provided in this Section 8.04(b), shall be the sole and exclusive remedy of the Terminating Party against the Breaching Party and its Affiliates for any and all Losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with this Section 8.04(b), neither the Breaching Party nor any of its Affiliates or their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(c) If this Agreement is validly terminated pursuant to Section 8.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of Section 5.20 and the confidentiality provisions of Section 10.22 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 9, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

(b) any claim asserted against Buyer or Buyer's Affiliates that, if meritorious, would constitute or give rise to a breach of any of Seller's representations and warranties as the direct cause of such claim;

(c) the nonfulfillment or breach of any covenant of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(d) the Excluded Liabilities;

(e) any actual damages (including reasonable attorneys' fees) resulting from claims by any creditor of Seller relating to a claim in existence as of the Closing Date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable state or federal insolvency, bankruptcy, bulk sales, fraudulent conveyance or creditors' rights Legal Requirements; and

(f) any liabilities, costs or expenses incurred by Buyer or its Affiliates in connection with the Transfer Act Activities contemplated by Section 5.08.

9.02. Seller's Limitations. Seller will have no liability under Section 9.01(a) and no claim will accrue against Seller under Section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 9.01(a) exceeds $675,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud.

9.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 9, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in or breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

(b) the nonfulfillment or breach of any covenant of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities; and

(d) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

9.04. Buyer's Limitations. Buyer will have no liability under Section 9.03(a) and no claim will accrue against Buyer under Section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 9.03(a) exceeds $675,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer.

9.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 9 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the

Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 9.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided*, however, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld or delayed) and (B) the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the

Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within 60 days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be resolved pursuant to Section 10.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within ten days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 10.20.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such

Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 9.05(a)(i) and Section 9.05(b)(i), as applicable.

9.06. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of Buyer to investigate Seller and the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations, warranties and covenants of the other in this Agreement. The representations, warranties and covenants of Seller and Buyer in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 2.04, 3.01, 3.02, 3.03, 3.11, 4.01, 4.02, 4.04, 8.04(b), 8.04(c), 8.04(d), 9.01(b)-(e), 9.03(b)-(d), 10.15, 10.20, 10.22 and 10.23, (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.05, 3.07, 3.11, 3.12(a), 3.13, 3.17, 3.22, 3.24 and 3.28, and (c) until the second anniversary of the Closing Date in the case of all other representations, warranties and covenants, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before the expiration of such representation or covenant until the claim for indemnification has been satisfied or otherwise resolved as provided in this Article;

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, or intentional nonfulfillment or breach of any covenant in this Agreement or any Closing Document, all representations, warranties and covenants that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach; and

(iii) covenants to be performed or complied with after the Closing Date will survive the Closing until 60 days after the end of the term specified in such covenant, or, if no term is specified, indefinitely.

9.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee

under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any third party claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

9.08. Indemnity Reserve. Seller agrees to maintain an indemnity reserve in the amount of $7,500,000 (Seven Million Five Hundred Thousand Dollars) for a period of three years after the Closing so that Buyer will have meaningful financial recourse against Seller for indemnification claims; provided, however, that (a) if, as of the third anniversary of the Closing Date, Buyer has pending indemnification claims, then Seller shall maintain an indemnity reserve in the amount of Buyer's Indemnified Person's pending bona fide claims until final resolution of such matters, and (b) if Buyer has not yet received written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" as contemplated by Section 5.08 that the Establishment Real Properties have been remediated in full compliance with the Connecticut Remediation Standard Regulations, then the indemnification reserve shall be extended for an additional period until such written approval has been received by Buyer. Notwithstanding the foregoing, in no circumstance shall the indemnification reserve established by this section 9.08 be extended beyond the fifth anniversary of the Closing Date.

10. GENERAL

10.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, Seller shall update its Schedules such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner. It shall be deemed a condition precedent to the obligations of Buyer that each of the Schedules, Exhibits, and related documents, instruments, books, and records shall meet with the approval of Buyer. If Buyer, in its reasonable discretion, determines that it should not consummate the transactions contemplated by this Agreement because of any information contained in a Schedule, Exhibit, or other instrument that is delivered to Buyer after the execution of this Agreement, then Buyer may terminate this Agreement on or before the Closing by giving written notice thereof to Seller.

(b) Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule

identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself).

10.02. Equitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 9).

10.03. Other Owners of Assets. Buyer, Seller and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement. Notwithstanding the foregoing, the Parties acknowledge and agree that Seller shall not make pursuant to this Agreement, and this Section 10.03 shall not otherwise suggest, any representation, warranty or other commitment as to the Subsidiaries of Seller listed on Schedule 10.03.

10.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 10.14 hereof, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior

executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 10.04(a) within 30 days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

10.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

10.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

10.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Contract, claim or right; provided, however, that such obligation shall be of no further force and effect if Seller and Buyer determine that such consent or approval will not be forthcoming.

10.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed. The Parties will use commercially reasonable efforts to file as soon as practicable and pursue all necessary regulatory approvals required in connection with this Agreement.

10.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

10.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any litigation or proceedings among the Parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

10.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate an Affiliate to purchase any or all of the Assets, including the Hospital Businesses, *provided* that Tenet shall unconditionally guarantee any and all obligations of such Affiliate pursuant to Section 10.23, and (ii) Buyer and Tenet shall be permitted to grant a security interest in and collaterally assign and transfer all of their rights, interests and benefits, but not their obligations, under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of Seller.

10.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms (except as otherwise provided in Section 5.03(d)).

10.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

10.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: **VHS Eastern Connecticut System, LLC**

_____

_____

_____

Attn:
Fax:
Email:

with a copy to (which shall not constitute notice):

Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
Attn: General Counsel
Fax: 469-893-7147
Email: audrey.andrews@tenethealth.com

and

Yale-New Haven Health Services Corporation

_____

_____

_____

Attn:
Fax:
Email:

If to Seller: Eastern Connecticut Health Network, Inc.

General Counsel
Eastern Connecticut Health Network
71 Haynes Street
Manchester, Connecticut 06040
Attn: Joyce Tichy
Fax:
Email: jtichy@echn.org

with a copy to (which shall not constitute notice):

Ropes & Gray LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Attn: Anne Ogilby
Fax: 617-235-0234
Email: anne.ogilby@ropesgray.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

10.15. Misdirected Payments; Physician Loans. After Closing, (a) Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates) constituting or in respect of the Assets and Assumed Liabilities, and (b) Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets in which case Seller shall not be liable for any such repayment. If Buyer suffers any deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence), Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. Any amounts payable pursuant to this Agreement that are due Buyer by Seller or one of its Affiliates, or due Seller by Buyer or one of its Affiliates, may be offset against monies or other funds owed by the party entitled to receive payment to the party required to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause its Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

10.16. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement

would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

10.17. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate governmental agencies shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

10.18. Entire Agreement; Amendment. This Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 9.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

10.19. Counterparts; Transmission by Electronic Means. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

10.20. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not

including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A. during such period.

10.21. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

10.22. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller and Buyer (and their respective Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party. With respect to information provided by a party to the other party in connection with and relative to this proposed transaction, the Confidentiality Agreement, dated June 29, 2012, between Vanguard Health Systems, Inc., an Affiliate of Tenet, and Seller shall remain in effect until Closing and shall be binding upon Buyer for purposes of confidentiality.

(b) At all times before and after the Closing, Seller, on the one hand, and Tenet and Buyer, on the other hand, will consult with the other before issuing or making any reports, statements or releases to the public with respect to this Agreement or the transactions contemplated by this Agreement and will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

10.23. Guarantee of Buyer's Obligations. Tenet, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, Tenet will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 9.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. Tenet's obligations under this Section 10.23 shall not be affected or discharged in any way by any Proceeding with respect to Buyer

under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

[*Signature Page Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____

Title: _____

VHS EASTERN CONNECTICUT HEALTH SYSTEM, LLC

By: _____

Title: _____

TENET HEALTHCARE CORPORATION

By: _____

Title: _____

VHS OF CONNECTICUT, LLC

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 10.03.

ACKNOWLEDGED BY:

THE MANCHESTER MEMORIAL HOSPITAL

By: _____

Title: _____

THE ROCKVILLE GENERAL HOSPITAL, INCORPORATED

By: _____

Title: _____

ECHN ELDERCARE SERVICES, INC.

By: _____

Title: _____

VISITING NURSE AND HEALTH SERVICES OF CONNECTICUT, INC.

By: _____

Title: _____

A CARING HAND, LLC

By: _____

Title: _____

ECHN ENTERPRISES, INC.

By: _____

Title: _____

HAYNES STREET PROPERTY MANAGEMENT, LLC

By: _____

Title: _____

ECHN CORPORATE SERVICES, INC.

By: _____

Title: _____

MEDICAL PRACTICE PARTNERS, LLC

By: _____

Title: _____

CLINICALLY INTEGRATED NETWORK OF EASTERN CONNECTICUT, LLC

By: _____

Title: _____

CONNECTICUT HEALTHCARE INSURANCE COMPANY, INC.

By: _____

Title: _____

Exhibit A

Form of Transitional Services Agreement

See attached.

Exhibit B

Form of Limited Power of Attorney

See attached.

Schedule 1.02

Persons with "Seller's Knowledge"

Peter Karl	President and Chief Executive Officer
Dennis McConville	Senior Vice President and Chief Strategy Officer
Michael Veillette	Senior Vice President and Chief Financial Officer
Joel J. Reich, M.D.	Senior Vice President, Medical Affairs and Chief Medical Officer
Deb R. Gogliettino	Senior Vice President and Chief Human Resources Officer
Deborah A. Parker	Executive Vice President and Chief Clinical Officer

EXHIBIT 3 – CHARTIS BACKGROUND

The Chartis Group

ECHN Affiliation Strategy Engagement
Biographies for Chartis Group Project Team

R. Christopher Regan, Managing Director

Mr. Regan is a founding partner and Managing Director of The Chartis Group. He has a wide range of experience in the healthcare consulting field having directed a variety of strategic, operational and organizational engagements for healthcare clients across the country over a twenty eight year career. Mr. Regan previously served as President of H-Works, the consulting division of The Advisory Board Company. He is a frequent speaker at industry conferences, forums and Board Retreats.

Prior to co-founding The Chartis Group and serving as President of H*Works, Mr. Regan spent fourteen years at CSC Healthcare and its predecessor APM Incorporated where he played an integral role in building the firm from 30 to over 300 staff. While at CSC/APM, Mr. Regan was as one of twelve senior partners leading the firm's healthcare consulting practice. He also served as the National Director of the firm's Clinical Effectiveness practice.

Mr. Regan's recent client work has focused in particular on competitive strategy, mergers and acquisitions and physician joint venture development. He has completed several prior engagements for ECHN in recent years.

Mr. Regan is a Trustee of Ascension Health Ventures, Seacor Holdings, Inc. and Hamilton College. He holds an M.B.A. in Finance and Accounting from New York University's Graduate School of Business Administration and a B.A. in English Literature from Hamilton College.

Zal Sarkari, Principal

Mr. Sarkari, a Principal with the Chartis Group, has over seventeen years' experience consulting to the Healthcare industry. Mr. Sarkari has worked in academic health system, integrated delivery network and community hospital settings assisting clients in the areas of strategic planning, service line planning, program evaluation and development, physician alignment, patient access, and revenue cycle/reimbursement management.

Prior to joining Chartis, Mr. Sarkari was a Partner with CSC Healthcare's Consulting Group where he led a wide range of strategic and operational consulting engagements. Mr. Sarkari was also previously a Director with OR International where he led the development of specialty hospitals internationally.

Representative engagements include:

- For a West Coast University Hospital Mr. Sarkari managed a project to develop a long term strategic and business plan for two service lines: kidney, liver and pancreas transplantation service and the cardiac service – focusing on volume and bottom line growth over five years. Mr Sarkari helped the organization develop the service line vision, strategies required to achieve the vision and quantified the resource requirements (including space, capital and human resource

requirements) and benefits (including financial, educational and research benefits). The project culminated with the creation of a succinct business plan that the organization is using as a workplan as well as to gain agreement among internal and external constituents.

- Mr. Sarkari assisted a large Integrated Delivery Network in developing a five year strategic and financial plan to reposition the medical center for success in an increasingly managed-care-dominated operating environment. The strategies were iteratively developed using simulated modeling of a variety of possible scenarios that were tailored to each market segment the organization competed in. The model allowed the hospital and faculty practice plan to continuously forecast detailed financials and volumes as market and internal circumstances change – so that the strategies can be positioned appropriately.
- For a Northeastern Academic Medical Center, Mr. Sarkari managed a multi-year project to comprehensively improve patient access, scheduling, registration, coding, billing and follow-up processes at the two main hospitals and the 650-academic physician group. This project achieved $25 million net revenue and $46 million cash improvements within the first fiscal year – both of which have been sustained and added to in each subsequent fiscal year.

Mr. Sarkari holds a BA from Yale University.

Keith Dickey, Principal

Mr. Dickey, a Principal with The Chartis Group, has more than 18 years of experience providing strategic and financial advisory services to the healthcare industry. He has advised a broad range of healthcare providers, including integrated delivery systems, academic medical centers, children's hospitals, provider-sponsored managed care organizations, senior care facilities, clinical laboratories and medical equipment companies. Mr. Dickey's areas of focus include enterprise and service line strategies; strategic capital planning; valuations; mergers, acquisitions and joint ventures, and financial advisory services in connection with public and private capital markets transactions (debt and equity).

Prior to joining The Chartis Group, Mr. Dickey worked as a healthcare investment banker, first at Shattuck Hammond Partners from 1996 until 2006, where he served as Chief Knowledge Officer and later Principal, and subsequently as a senior healthcare investment banker at the successor firms of Morgan Keegan & Company and then Raymond James and Associates following Morgan Keegan's acquisition of Shattuck Hammond Partners in 2007 and its merger with Raymond James in 2012. From 2006 to 2010, Mr. Dickey also owned and operated Butter's Fine Food and Wine, a retail gourmet food and wine business in Concord, NH. From 1992 to 1996, Mr. Dickey was a consultant at APM, Inc., a healthcare management consulting firm, where he focused on health system strategy and hospital operations re-engineering projects.

Mr. Dickey holds a Ph.D. and M.A. in Classical Archaeology from Bryn Mawr College and an A.B., magna cum laude, from Dartmouth College. He was a Fulbright scholar to Greece in 1987.

The Chartis Group

About The Chartis Group

chartis (chär•tis), *n.* (from Greek) the art and practice of map making that combines the disciplines of reason, science, aesthetics and technical ability to create an accurate and balanced representation capable of communicating large amounts of information quickly and effectively.

The Chartis Group

- Founded in 2001 to support the nation's top healthcare organizations in their most critical pursuits
- 75+ highly experienced healthcare professionals who apply a distinctive knowledge of healthcare economics, markets, and organizational dynamics to help clients achieve unequaled results
- Tailored, practical solutions through data-driven critical thinking, rigorous analytics and creativity coupled with extensive industry experience

Our mission is to materially improve the delivery of healthcare in the world.

BOSTON CHICAGO NEW YORK SAN FRANCISCO

1

About The Chartis Group

We are privileged to serve a variety of clients from across the country.

Sample of Chartis Clients by Region



4

The Chartis Group

Sample Affiliation Engagements

We have supported over 50 affiliation engagements — Partial List

Client	Location	Scope of Assistance
Advocate HealthCare	Chicago, IL	System sizing, consolidation and expansion strategy; support for individual affiliations in support of overall strategy
Central DuPage Hospital	Winfield, IL	System strategic options; individual merger evaluations
Dartmouth Hitchcock	Lebanon, NH	System formation strategy and merger support
BayCare Health System	Tampa, FL	Evaluation of a regional academic affiliation
Vanguard Healthcare	Various markets	Evaluation of system expansion and specific acquisition opportunities in multiple markets
Montefiore Medical Center	Bronx, NY	Evaluation of two potential mergers with other area hospitals; evaluation of medical group affiliation options
Memorial Sloan Kettering	New York, NY	Affiliation strategy; evaluation of potential merger with a leading NYC AMC
Healthstar / Stellaris Health Network	Westchester, NY	Developed a merger strategy and business case for a four hospital merger
Hartford Healthcare / New Britain	Hartford, CT	Advised New Britain Board on affiliation opportunities. Developed Vision & Business Case for merged system.
Mount Sinai Hospital and Health System	New York, NY	Created a merger/affiliation strategy leading to multiple mergers, acquisitions and affiliations

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Sample Affiliation Engagements

We have supported over 50 affiliation engagements — Partial List

Client	Location	Scope of Assistance
St. Vincent Health System	Indianapolis, IN	Developed strategy to form St. Vincent Health System – including multiple mergers and acquisitions involving various affiliates
St. Mary's of Evansville/ Welborn Baptist Hospital	Evansville, IN	Developed a merger strategy, deal structure and post-merger integration support for a Catholic and a non-Catholic hospital
Booth Memorial Medical Center	Queens, NY	Assisted in all phases of the acquisition of Booth Memorial by New York Hospital / Cornell Medical Center
Catholic Health Services of Long Island	Long Island, NY	System formation strategy and multiple mergers and acquisitions to create one of the two leading health systems on Long Island
Maine General Medical Center	Augusta, ME	Developed new operating models and financial projections for different hospital merger scenarios
Port Huron Hospital – Trinity Health	Port Huron, MI	Merger vision, rationale and business case development for potential local merger
Greenwich Hospital / Yale New Haven Health System	Greenwich, CT	Created an affiliation strategy for Greenwich Hospital leading to its merger into the Yale New Haven Health System
Waterbury and Saint Mary's Hospitals	Waterbury, CT	Developed detailed business case quantifying the benefits of a local merger between a Catholic and a non-sectarian hospital in Waterbury, CT
West Penn/Allegheny	Pittsburgh, PA	Managed post-merger integration and savings program (PMO) resulting in $90 million annual financial improvement and $450 million refinancing

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EXHIBIT 4 – REQUEST FOR PROPOSAL TO YNHHS AND VANGUARD

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

November 26, 2012

Keith Pitts
Vice Chairman
Vanguard Health Systems, Inc.
20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215

Dear Keith,

Thank you for the interest you have expressed in forming a strategic affiliation between Eastern Connecticut Health Network ("ECHN" or "Health System") and Vanguard Health Systems ("Vanguard"). It is clear that ECHN and Vanguard share a common commitment to improve the well-being of Connecticut residents by offering high-quality, compassionate, safe and efficient healthcare services.

As we discussed during our recent meeting, ECHN is a well-regarded, community-based health system committed to enhancing care delivery for patients in its core markets east of the Connecticut River. Close ties with the communities it serves have helped ECHN build an accomplished, loyal medical staff and achieve consistent growth in clinical service delivery and patient care revenue.

After careful consideration, the Board and Executive leadership of ECHN have determined that a strategic affiliation has the potential to offer our combined organizations and those they serve enduring benefits in the changing health care marketplace. Therefore, the ECHN leadership is issuing this Request for Proposal (RFP) to a limited number of organizations like yours. The RFP has been written to evoke rather than define your thinking as to how our two organizations can work together to meet our shared visions. In this context, ECHN is willing to consider a range of transaction alternatives based upon the anticipated strategic and financial benefits to ECHN and the communities it serves.

Pursuant to the Confidentiality Agreement previously executed by you, select individuals within your organization (to be identified by you) will be given access to an online data room containing an initial set of confidential due diligence information regarding ECHN. If after review of the information contained therein, you wish to proceed to the next phase of the process, we request that you submit a non-binding Indication of Interest no later than **5p.m. ET on January 8, 2013.**

Your response and any questions concerning this RFP should be addressed to:

Mr. Dennis P. McConville
Senior Vice President for Strategic Planning,
Marketing & Communications,
Eastern Connecticut Health Network, Inc.,
Via email at dmcconville@echn.org,
Via phone at (860) 533-3429.

We look forward to receiving your response.

* * * * *

ECHN's Mission and Future Vision

ECHN is a vibrant health system that serves several communities located on the east side of the Hartford Metropolitan Region. Our system is comprised of two acute care inpatient facilities, Manchester Memorial Hospital and Rockville General Hospital (having 249 and 102 adult licensed beds respectively), a skilled nursing and rehabilitation center (having 130 beds), multiple imaging and ambulatory centers, a home health care agency and various other ancillary health services. ECHN also has 435 physicians and 85 allied health professionals on its medical staff.

ECHN seeks a partner that shares its Mission to improve the well-being of the population by providing high-quality, compassionate healthcare. Likewise it seeks a partner that shares its Vision to be patients' first choice for excellence in healthcare**.** In this context, ECHN believes that it has a significant opportunity to serve a broader patient base with improved clinical capabilities that are more conveniently accessible. We are committed to offering high-quality, cost-effective services. There are four principal components to ECHN's future Vision:

1. **Be the 'Provider of Choice' east of the Connecticut River**: Ensure that ECHN attracts patients and providers based on its quality, service, accessibility and affordability.

2. **Provide a broader and full spectrum of services**: Expand ECHN's patient base across the markets it serves in primary and specialty care services. Deepen our Health System's service foot print, enhance physician retention and recruitment, and grow patient volumes.

3. **Improve finances (margins, cash flow and capital access) to be able to continue to invest in the organization's capabilities**: Invest in state-of-the-art equipment, technologies and upgrade facilities. Bolster financial performance through revenue and cost improvements while strengthening the organization's balance sheet.

4. **Build population health management and accountable care capabilities:** Strengthen capabilities to manage care across the continuum in an accountable care environment. Participate in new value-based contracting vehicles.

ECHN leadership has developed partnership selection criteria as part of its affiliation planning process. These criteria include the following desired attributes for our potential partner organization:

- Evidence of strong cultural compatibility,
- A compelling Vision and a winning strategy in the market,
- Clear organizational strength and operational acumen,
- A solid financial foundation in terms of attractive margins and access to capital,
- A track record of successfully integrating partner organizations like ours.

It is important to ECHN that our potential partner organization has a compelling strategy for melding our Missions and Visions in a way that brings new benefit to those we both serve. Likewise, it is important that our future partner has a compelling plan for growing our combined organizations. We believe that ECHN can contribute significant benefits and assets to a potential partner and that these assets would be further enhanced by a successful partnership. Our assets include a high quality medical, nursing and management staff, a track record of providing high quality, low cost care that is customer focused, and a well distributed network of acute and non-acute care facilities that serve a broad patient base. We are seeking a "win-win" partnership that strengthens both our organizations and enhances our ability to bring new benefit to the communities we serve.

Requested Affiliation Proposal Elements

Please address the items below in your non-binding Indication of Interest. ***Since your responses will be utilized to determine whether, and with whom, ECHN may pursue further discussions, your documentation should include as much specificity as possible***. Your Indication of Interest need not be limited to these items, and may include other items you believe should be considered.

Form of Transaction, Price, and Type of Consideration

1. Please specify the form and structure of transaction or affiliation you would propose.
    - ECHN will consider a range of transaction structures, including a sale of all of ECHN's assets, a merger or transfer of Health System sponsorship, or a joint venture structure.
2. Please specify the financial terms of your proposal, based upon the structure outlined above, i.e., the valuation/purchase price, how debt, pension and other liabilities will be assumed, disposed or restructured, form of consideration, future capital commitment, any assets or liabilities to be excluded from the transaction. In this regard, the ECHN Community Healthcare Foundation is excluded from the potential transaction.

Vision and Operations

3. How will affiliation with your organization help ECHN achieve its vision and goals as outlined above?

4. Based on your vision of the market, how can you help us improve the range of healthcare services available within the communities ECHN serves and access to those services?

5. If you have facilities in ECHN's primary and secondary service areas or within the city of Hartford, how do you envision ECHN working with these facilities? What services, if any, would you anticipate growing, adding or eliminating at the local community level? What is the process for making these types of decisions?

6. Would you propose to integrate our medical staffs? If so, what recommendations would you suggest?

7. How would the proposed affiliation enhance clinical quality, safety, service and patient satisfaction? Please describe the ways in which you measure quality and safety. Discuss how your hospitals perform in terms of CMS quality indicators and patient satisfaction.

8. How would a strategic transaction with your organization enhance ECHN's ability to attract and retain high quality physicians to the medical staff community? Please discuss:

    - Your intentions concerning the current medical staff, medical teaching program and residency program,

    - Your organization's capabilities regarding physician recruitment and retention,

    - Your organization's strategy for fostering clinical integration and alignment with employed and independent medical staff.

9. If you are proposing a joint venture/joint sponsorship model, please describe your anticipated operational approach to ECHN, including anticipated operating efficiencies and capital avoidance, if any, resulting from the proposed transaction and any savings associated with such efficiencies/avoidance.

Governance and Management

10. As applicable, based upon your proposed affiliation structure, please discuss the governance structure and continuing role of ECHN and/or the ECHN Board in the governance of the Health System, and if applicable, at your health system corporate level. Examples of comparable transactions where you have employed the proposed structure would be helpful.

11. Please indicate the senior management positions you would anticipate having at ECHN, as well as the roles and positions these individuals would have in the organization post-affiliation.

12. Please indicate your position regarding retention of existing employees and compensation/benefit levels, including the honoring of years of service for benefit programs (including pension and other retirement plans).

13. Please describe your willingness, if requested, to commit to the following either through reserved powers to ECHN or as part of an affiliation/joint venture agreement. To the extent that some of these commitments are in the future and subject to changes in the market/context, please describe

the requirements these initiatives have to meet in order to be implemented (e.g., an ROI within a period of time requirement, system Board approval, etc.). Additionally, to the extent there are capital investments required, please describe the structure of the capital pool(s) that these programs would be accessing and the mechanism for accessing them (e.g., would you segregate a certain capital pool for these programs over a period of time, would these programs be competing for capital with other facilities in your system, etc.).

- ***Service Commitments/Enhancements***

  i. ECHN sees promise/opportunity to develop, expand or enhance service in the following clinical areas. Please comment on how affiliation with your organization would support and enable clinical program development and/or expansion, how you approach medical staffing, and/or facility and equipment enhancements for the following services:

     1. Enhancing and expanding the Primary Care capabilities, in existing and new markets,
     2. Cardiovascular Services, including Diagnostic and Interventional Catheterization, Electrophysiology and Pacemaker Programs,
     3. Cancer Care, including Medical Oncology and specialty Oncologic Surgery,
     4. Maternal Fetal Medicine /Perinatology,
     5. Bariatric Surgery,
     6. Orthopedics, with an emphasis on Spine Surgery and Joint Replacement Surgery,
     7. Pain Management Service/Program.

  ii. Please discuss your willingness to commit to maintaining or enhancing Rockville and Manchester Hospitals as full-service inpatient facilities,

  iii. Maintaining or enhancing ECHN's current non-acute programs, such as the skilled nursing and rehabilitation center and the visiting nurse service, as well as joint ventures, such as Tolland Imaging Center, Evergreen Endoscopy Center, Eastern Connecticut PHO, Community Cancer Care and others,

  iv. Maintaining or enhancing ECHN's Family Practice Residency Program and its teaching program with the University of New England - College of Osteopathic Medicine (UNECOM).

Capital Investments

v. Transitioning capacity to private rooms,

vi. Upgrading and expanding obstetrics and neonatal nursery,

vii. Upgrading and expanding the inpatient operating rooms,

viii. Renovating and expanding the radiology suite,

ix. Investing in medical equipment,

x. Electronic Medical Record system replacement and implementation,

xi. New care management capabilities and systems.

Affiliation and Board Structure

xii. Maintain local Board powers in the following activities:

- Fundraising,
- Overseeing medical staff credentialing,
- Participating in the selection of the system CEO and other senior management,
- Reviewing local quality and service goals,
- Reviewing annual operating and capital budgets,
- Reviewing any reduction in force plans
- Monitoring local quality, service, and financial performance.

xiii. Local Board participation at the system level, e.g., in strategic planning, capital investments, etc.,

Additional Information / Due Diligence Required

14. Please provide a detailed list of additional information required if selected to proceed with further due diligence.

15. Please indicate the names of the financial, legal or other advisors who will be engaged in connection with the transaction.

Timing, Required Approvals and Contingencies

16. Upon the selection of a preferred partner, ECHN intends to promptly negotiate a Letter of Intent ("LOI") incorporating the key terms of the transaction. Please indicate the estimated time following the execution of an LOI your organization would typically require to conduct a

confirmatory due diligence, negotiate a Definitive Purchase Agreement and consummate the transaction.

17. Please discuss any corporate or regulatory approvals required to complete the transaction, the time required for those approvals and any potential risks that could increase the time required or stop the process.

18. Please indicate any financing or other contingencies or material conditions to the consummation of the transaction, including any key assumptions in your valuation of ECHN that, if revised, could have a significant impact on the purchase price or financial terms.

* * * * *

After receipt of Indications of Interest, ECHN will review the submissions. If at that time ECHN elects to move forward with a transaction, it will conduct further discussions, as necessary, in order to identify a preferred partner with which to negotiate a non-binding Letter of Intent. In assessing the qualifications of potential strategic partners, ECHN will consider in its sole discretion such factors as: the benefit of the transaction to ECHN and the community, the amount and form of consideration (if any), the ability of the potential partner to consummate the transaction in a timely manner, and such other factors as are deemed relevant.

ECHN reserves the unilateral right to alter or terminate the transaction process at any time and for any reason. In addition, ECHN reserves the right to terminate discussions with any or all prospective purchasers, to reject any or all proposals, or to negotiate with any party regarding the transaction, and without obligation to disclose any reasons therefor. This letter and any materials supplied in connection therewith shall be Confidential Information as defined by the Confidentiality Agreement previously signed by your organization.

Mr. McConville from ECHN and Mr. Sarkari from the Chartis Group, whose contact information is listed below, will be available throughout the process to respond to questions. However, in no event should other management, Board members or employees of ECHN be contacted directly.

Our advisors from The Chartis Group will be following up with you or your representatives in the near future to arrange for access to the online data room.

Thank you for your consideration and cooperation. We appreciate your interest in this opportunity.

Sincerely,

Dennis G. O'Neill, M.D.
Chairman, Board of Trustees

PERMITTED CONTACTS:

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Senior Vice President for Strategic Planning, Marketing & Communications,
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Via email at dmcconville@echn.org,
Via phone at (860) 533-3429.

Mr. Zal Sarkari
The Chartis Group
Via email at zsarkari@chartis.com,
Via phone at (646) 483-3395.

ECHN℠
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

November 26, 2012

Marna P. Borgstrom
President & Chief Executive Officer
Yale-New Haven Hospital and Yale New Haven Health System
20 York Street
New Haven, CT 06510

Dear Marna,

Thank you for the interest you have expressed in forming a strategic affiliation between Eastern Connecticut Health Network ("ECHN" or "Health System") and Yale New Haven Health System ("Yale"). It is clear that ECHN and Yale share a common commitment to improve the well-being of Connecticut residents by offering high-quality, compassionate, safe and efficient healthcare services.

As we discussed during our recent meeting, ECHN is a well-regarded, community-based health system committed to enhancing care delivery for patients in its core markets east of the Connecticut River. Close ties with the communities it serves have helped ECHN build an accomplished, loyal medical staff and achieve consistent growth in clinical service delivery and patient care revenue.

After careful consideration, the Board and Executive leadership of ECHN have determined that a strategic affiliation has the potential to offer our combined organizations and those they serve enduring benefits in the changing health care marketplace. Therefore, the ECHN leadership is issuing this Request for Proposal (RFP) to a limited number of organizations like yours. The RFP has been written to evoke rather than define your thinking as to how our two organizations can work together to meet our shared visions. In this context, ECHN is willing to consider a range of transaction alternatives based upon the anticipated strategic and financial benefits to ECHN and the communities it serves.

Pursuant to the Confidentiality Agreement previously executed by you, select individuals within your organization (to be identified by you) will be given access to an online data room containing an initial set of confidential due diligence information regarding ECHN. If after review of the information contained therein, you wish to proceed to the next phase of the process, we request that you submit a non-binding Indication of Interest no later than **5p.m. ET on January 8, 2013.**

Your response and any questions concerning this RFP should be addressed to:

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Senior Vice President for Strategic Planning,
Marketing & Communications,
Eastern Connecticut Health Network, Inc.,
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Capital Investments

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- Reviewing annual operating and capital budgets,
- Reviewing any reduction in force plans
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xiii. Local Board participation at the system level, e.g., in strategic planning, capital investments, etc.,

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Timing, Required Approvals and Contingencies

16. Upon the selection of a preferred partner, ECHN intends to promptly negotiate a Letter of Intent ("LOI") incorporating the key terms of the transaction. Please indicate the estimated time following the execution of an LOI your organization would typically require to conduct a

confirmatory due diligence, negotiate a Definitive Purchase Agreement and consummate the transaction.

17. Please discuss any corporate or regulatory approvals required to complete the transaction, the time required for those approvals and any potential risks that could increase the time required or stop the process.

18. Please indicate any financing or other contingencies or material conditions to the consummation of the transaction, including any key assumptions in your valuation of ECHN that, if revised, could have a significant impact on the purchase price or financial terms.

* * * * *

After receipt of Indications of Interest, ECHN will review the submissions. If at that time ECHN elects to move forward with a transaction, it will conduct further discussions, as necessary, in order to identify a preferred partner with which to negotiate a non-binding Letter of Intent. In assessing the qualifications of potential strategic partners, ECHN will consider in its sole discretion such factors as: the benefit of the transaction to ECHN and the community, the amount and form of consideration (if any), the ability of the potential partner to consummate the transaction in a timely manner, and such other factors as are deemed relevant.

ECHN reserves the unilateral right to alter or terminate the transaction process at any time and for any reason. In addition, ECHN reserves the right to terminate discussions with any or all prospective purchasers, to reject any or all proposals, or to negotiate with any party regarding the transaction, and without obligation to disclose any reasons therefor. This letter and any materials supplied in connection therewith shall be Confidential Information as defined by the Confidentiality Agreement previously signed by your organization.

Mr. McConville from ECHN and Mr. Sarkari from the Chartis Group, whose contact information is listed below, will be available throughout the process to respond to questions. However, in no event should other management, Board members or employees of ECHN be contacted directly.

Our advisors from The Chartis Group will be following up with you or your representatives in the near future to arrange for access to the online data room.

Thank you for your consideration and cooperation. We appreciate your interest in this opportunity.

Sincerely,

Dennis G. O'Neill, M.D.
Chairman, Board of Trustees

PERMITTED CONTACTS:

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Senior Vice President for Strategic Planning, Marketing & Communications,
Eastern Connecticut Health Network, Inc.,
Via email at dmcconville@echn.org,
Via phone at (860) 533-3429.

Mr. Zal Sarkari
The Chartis Group
Via email at zsarkari@chartis.com,
Via phone at (646) 483-3395.

EXHIBIT 5 – PARTNERING WORKGROUP SUMMARY (MAY 30, 2013)

Partnering Workgroup Meeting
May 30, 2013

The following represents a summary of the discussion and opinions that were shared by the Partnering Workgroup regarding the second proposals for the benefit of the Transaction Committee:

Vanguard Health Systems-Yale New Haven Acquisition Proposal

- After extensive discussion, each person expressed the opinion that the Vanguard-Yale New Haven "best and final" proposal was superior to the other proposals received. Some of the specific reasons cited included:
  - The price would cover ECHN's liabilities, both for debt and pension, and in addition had the potential to fund the community foundation,
  - Their willingness to assume the pension with its liability,
  - That the cultural fit with Yale, Vanguard and ECHN was good,
  - And that Yale has a strong clinical brand.
- Several expressed the point that we still need to know what their willingness is to commit to a minimum capital spending plan.
- A question was asked about the impact of selecting Vanguard-Yale New Haven related to the continued ownership/participation of ECHN joint ventures that ECHN has with Hartford Hospital. (Ropes and Gray will be conducting an analysis of the effect on those joint ventures in the event that the recommended choice is Vanguard-Yale New Haven.)

[redacted] Acquisition Proposal

- It was observed that the acquisition price offered by [redacted] in its "best and final" proposal was not high enough to satisfy ECHN's debt or provide for the additional funding that would be needed for the pension (which would remain with ECHN). Also, it would not leave any proceeds to fund the community foundation. The shortfall is significant.
- There was concern expressed by several members regarding antitrust scrutiny of this proposal by the regulators [redacted]
- It was stated that while [redacted] was willing to cover the expense of a second request from the FTC (if we used their attorneys), the time required for that process is a concern and the potential that a transaction would be denied is a serious concern. Counsel estimated the likelihood of a second request at above 90%. During the year or so a second request is expected to consume, the financial condition of ECHN is likely to deteriorate and the market is likely to consolidate further, leaving fewer options in the event of a denial.

[redacted] Management Services Agreement Proposal

- Several individuals stated that the Management Services Agreement was insufficient from financial, strategic, and regulatory perspectives.
- It was observed that the second proposal did not sufficiently articulate the basis for $30mm in savings that is proposed over three years. Management has tried to obtain further specifics on these estimated savings but did not receive specific assurances.

Partnering Workgroup Meeting
May 30, 2013

- It was pointed out that the proposal did include $15mm for [redacted] to purchase a minority interest in ECHN and $15mm to fund joint ventures but that was not enough to provide for the capital needed, to defease ECHN's debt or to address the pension funding needed.
- A strategic concern was raised that over time ECHN would become dependent on [redacted] for management and its support services and would have difficulty unwinding the arrangement if it wanted to. Further, if it was determined that ECHN wanted or needed to merge or be acquired in the future, the market would likely have consolidated around it leaving few options and its value would be diminished.
- [redacted]

There was general discussion that it is in ECHN's best interest to make a decision soon given current financial challenges resulting from soft demand for outpatient services and from the continued uncertainty of government payments for services related to state budget proposals and the federal sequester.

Dennis McConville

EXHIBIT 6 – CORPORATOR VOTE

ECHN
Eastern Connecticut Health Network

Memorandum

To: ECHN Corporators

From: Dennis O'Neill, MD, Chairman of the ECHN Board of Trustees; Peter J. Karl, President & CEO

Date: April 10, 2014

RE: Sale of ECHN: ECHN Corporator Vote

In August 2013, ECHN signed a letter of intent to sell its assets to a joint venture between Tenet Healthcare Corporation (formerly Vanguard Health Systems) and Yale New Haven Health System. Over the next seven months, ECHN, Tenet and Yale New Haven officials worked diligently to negotiate a final Asset Purchase Agreement. In November 2013, ECHN Corporators received a 28 page document outlining the impact of health care reform, financial challenges, process for selecting a partner and explanation of our next steps. The elected Board of Trustees has worked tirelessly over the past two years to ensure that our communities east of the river will have continued local access to the highest quality healthcare. Their careful study, outreach, due diligence and deliberation led to the decision that the transaction with Yale New Haven and Tenet will ensure that ECHN's mission to improve your well-being by providing high quality, compassionate healthcare will continue as the healthcare delivery system is reformed across Connecticut, the region and the nation.

On April 9, an Asset Purchase Agreement was presented to the ECHN Board of Trustees for approval, and the trustees cast a unanimous vote in favor of the Asset Purchase Agreement.

With the Board of Trustees' approval, the Asset Purchase Agreement must now be presented to the 258 ECHN Corporators for their review. The terms of this Agreement are confidential in nature and we trust this information will not be shared with any parties except fellow ECHN Corporators. During the next 30 days, we ask that you review this information and ask us any questions or speak to us about any concerns by contacting ECHN at 860-646-1222 ext. 3645. On May 12th at 5:30 p.m., a special **Corporator only** vote meeting will be held at the Manchester Memorial Hospital Auditorium. You are encouraged to ask any questions during the May 12th meeting prior to the vote. Also, a special **Corporator only** educational session will be held on April 22nd, 2014 from 5-6:30 p.m. where you may ask questions and speak with Peter Karl, ECHN President & CEO, members of the Board of Trustees and legal counsel.

Enclosed with this correspondence you will find important information that we hope will help guide you through the vote process including:

- ECHN's Position Statement
- A summary of the Asset Purchase Agreement
- Explanation of the ECHN Corporator voting process and instructions
- Resolution of the Corporators
- A vote card and stamped reply envelope

A copy of the full Asset Purchase Agreement is available for review at the ECHN Administration Office at 71 Haynes Street, Manchester, CT. Please contact Chantal Perigo, office of the President at 860-646-1222 ext. 3645 to make arrangements to view this document. Your vote as a Corporator is crucial to the future of ECHN. We hope you will review these materials in detail and provide your support for this transaction.

ECHN℠
Eastern Connecticut Health Network

ECHN's Position Statement

ECHN is a health system made up of two hospitals and a variety of affiliates that, after nearly two years of careful due diligence and analyses, seeks to enter into an asset purchase agreement with a joint venture between Tenet Healthcare Corporation (NYSE: THC) and Yale New Haven Health System. The ECHN system would become controlled by a for-profit company. Nonetheless, the asset purchase agreement makes clear that Tenet and Yale New Haven would continue ECHN's longstanding commitments to providing charity care and healthcare benefits to the wider ECHN community. ECHN, if it were to remain an independent not-for-profit system, might not have the financial resources to keep these commitments in the future. Through this transaction, we believe that the ECHN system can continue its mission to improve your well-being by providing high-quality, compassionate healthcare to our community.

In this era of unprecedented health care reform, declining payments for health care services resulting from recent federal legislation, increasing hospital taxes and prolonged regulatory uncertainty leave ECHN challenged to reduce expenses at a time when we desperately need capital to invest in maintaining and improving our care delivery systems. The collaboration we hope to enter now with your approval will bring Tenet's considerable financial resources, scale and access to capital markets together with Yale New Haven's strong national clinical reputation, ensuring a strong future for healthcare in eastern Connecticut. Given ECHN's current economic position, we believe this transaction represents the best opportunity we have to continue to deliver high-quality care at the lowest possible cost and also preserve jobs throughout eastern Connecticut.

We have been careful and deliberate with our affiliation process. We have worked hard to consider the interests and engage all of our constituents in this process, including our patients, employees, medical staff, corporators, the communities we serve and legislative and union leadership.

We ask for your support and approval of the transaction contemplated by the Asset Purchase Agreement between ECHN, Tenet Healthcare and Yale New Haven Health Services, Inc. as presented here.

ECHN℠
Eastern Connecticut Health Network

ECHN Corporator Voting Instructions

As explained below, if you are unable or prefer not to attend the scheduled meeting of the Corporators described here, you may designate a proxy who will cast your vote by mailing the completed proxy card enclosed here to the designated address in advance of the scheduled meeting of the Corporators and as explained on the attached proxy card.

It is important that your vote is represented, whether you attend the Corporator only vote meeting in person or not. **To ensure your voice is heard, we urge you to vote promptly by completing and mailing the enclosed proxy card, in accordance with the instructions on your proxy card.** Alternatively, you may attend the May 12, 2014 vote meeting and cast your vote in person. Please send in your proxy even if you intend to attend the meeting, as presence in person will revoke your proxy.

Votes will be tallied and results reported immediately following the meeting of the Corporators on May 12th.

Each ECHN Corporator is entitled to one vote.

EASTERN CONNECTICUT HEALTH NETWORK, INC.
CORPORATOR MEETING
PROXY CARD

I, the undersigned Corporator of Eastern Connecticut Health Network, Inc. (the "Corporation") do hereby appoint Dennis O'Neill, M.D. and Peter Karl, or either of them, with full power of substitution, my duly authorized attorneys-in-fact and proxies for purposes of voting at the meeting of the Corporators of the Corporation to be held on May 12, 2014, and any continuation thereof, with respect to the proposed sale of all or substantially all of the assets of the Corporation to a Joint Venture between Tenet Healthcare Corporation and Yale New Haven Health Services Corporation and in connection therewith to vote with respect to approval of a proposed Asset Purchase Agreement and to act upon such other matters as may come before the meeting. I instruct my duly authorized attorneys-in-fact and proxies to cast my vote as follows (check one):

___ In favor of the attached resolutions approving the sale of substantially all the assets of the Corporation.

___ Against the attached resolutions.

IN WITNESS WHEREOF, I have hereunto set my hand as of the date set forth below.

_____ Dated: _____, 2014

Print Name

_____

Signature

YOUR PROXY MUST BE RECEIVED BY THE OFFICE OF THE PRESIDENT OF EASTERN CONNECTICUT HEALTH NETWORK C/O CHANTAL PERIGO BY 12:00 NOON EASTERN TIME ON MAY 12, 2014 IN THE POSTAGE PAID ENVELOPE PROVIDED.

EASTERN CONNECTICUT HEALTH NETWORK, INC.

RESOLUTIONS OF THE CORPORATORS

May 12, 2014

WHEREAS, the Board of Trustees of Eastern Connecticut Health Network, Inc. (the "Corporation") has engaged in an extensive study of the health care market and future prospects and alternatives facing the Corporation; and

WHEREAS, after conducting such extensive study and considering the likelihood of continuing changes in the health care market and ongoing financial pressures, the Board of Trustees of the Corporation has negotiated that certain Asset Purchase Agreement by and among the Corporation and its affiliates pursuant to which substantially all of the assets of the Corporation and its affiliates will be sold to a limited liability company that is indirectly owned by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation (the "Asset Purchase Agreement"); and

WHEREAS, the Board of Trustees of the Corporation voted at its meeting of April 9, 2014 to approve the Asset Purchase Agreement as being in the best interest of the Corporation and its affiliates and to authorize the execution of the Asset Purchase Agreement by certain officers of the Corporation.

NOW, THEREFORE, be it resolved as follows:

Asset Purchase

RESOLVED: That the sale of substantially all the assets of the Corporation pursuant to the Asset Purchase Agreement is approved.

General Authorization

RESOLVED: That the President and CEO, Treasurer and Secretary of the Corporation be and they hereby are, and each of them acting singly is, hereby authorized from time to time, on behalf of the Corporation to take such other action as is necessary or desirable in connection with the transactions contemplated by the Asset Purchase Agreement.

CONFIDENTIAL – FOR ECHN CORPORATORS ONLY
DO NOT REPRODUCE OR DISTRIBUTE FURTHER
SUBJECT TO CONFIDENTIALITY AGREEMENT
WITH TENET HEALTHCARE CORPORATION

SUMMARY OF PROPOSED ASSET PURCHASE AGREEMENT BETWEEN EASTERN CONNECTICUT HEALTH NETWORK, INC., TENET HEALTHCARE AND YALE-NEW HAVEN HEALTH SERVICES, INC.

The proposed Asset Purchase Agreement ("APA"), commits Eastern Connecticut Health Network, Inc. ("ECHN") and its affiliates to the sale of substantially all of their assets to a newly-formed entity known as VHS Eastern Connecticut Health System, LLC ("Buyer") subject to satisfaction of various conditions. Buyer will be controlled by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale-New Haven Health Services Corporation ("Yale-New Haven"). The transaction described in the APA follows largely from the Letter of Intent signed on August 8, 2013 between ECHN, Vanguard Health Systems (since acquired by Tenet Healthcare Corporation), and Yale-New Haven.

1. Description of Buyer

A. Buyer is a Delaware limited liability company that is wholly-owned by VHS of Connecticut, LLC.

B. VHS of Connecticut, LLC is a holding company that is jointly owned by Tenet and Yale-New Haven.

C. Tenet unconditionally guarantees the full, punctual and complete performance by Buyer of all of Buyer's obligations under the APA.

2. Form of Transaction

A. Buyer will purchase substantially all of the assets of ECHN, including the properties, assets and businesses of, or ownership interests of ECHN affiliates in, the following entities (referred to collectively as the "Hospital Businesses"):
   - The Manchester Memorial Hospital
   - Rockville General Hospital, Incorporated
   - ECHN ElderCare Services, Inc.
   - Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC")
   - A Caring Hand, LLC
   - Clinically Integrated Network of Eastern Connecticut, LLC
   - Connecticut Healthcare Insurance Company
   - ECHN Corporate Services, Inc.
   - Medical Practice Partners, LLC
   - ECHN Enterprises, Inc.
   - Haynes Street Property Management, LLC

B. VHS Eastern Connecticut Health System will also purchase ECHN's interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law:
   - Evergreen Endoscopy Center, LLC
   - WBC Connecticut East, LLC
   - Aetna Ambulance Service, Inc.
   - Metro Wheelchair Service, Inc.
   - Ambulance Service of Manchester, LLC
   - Connecticut Occupational Medicine Partners, LLC
   - Eastern Connecticut Physician Hospital Organization, Inc.

C. VHS Eastern Connecticut Health System will also purchase ECHN affiliates' interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law:
   - Northeast Regional Radiation Oncology Network, Inc.
   - Tolland Imaging Center, LLC
   - Pathology Laboratory Services, LLC
   - Haynes Street Medical Associates, LLC
   - Haynes Street Medical Associates II, LLC
   - Evergreen Medical Associates, LLC
   - Evergreen Medical Associates II, LLC

D. There is no prohibition or restriction on Buyer's ability to sell assets or operations purchased under the APA, except as set forth in section 3 below.

3. Commitment to Maintain Key Clinical Operations and Community Support

A. For at least three years after the closing of the transaction, Buyer will continue operating Rockville General Hospital and Manchester Memorial Hospital in their current locations as acute care hospitals with emergency departments.

B. Also, for at least three years after the closing of the transaction, Buyer will maintain an ownership interest in ECHN's current post-acute care continuum of care network (*e.g.*, the service lines currently operated by VNHSC and ECHN ElderCare Services, Inc.) and require any joint venture involved with such post-acute care continuum of care network to maintain appropriate service lines during such three-year period.

C. Buyer will maintain and support financially ECHN's University of New England medical student and other health professions teaching programs, as well as ECHN's graduate medical education programs, while operating at a level not to exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by the Centers for Medicare and Medicaid Services.

D. Buyer will also ensure that each hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopt other policies that are at least as favorable to the community as ECHN's current policies).

4. Employment Matters

A. Buyer will offer employment as of the closing to substantially all employees of ECHN and its affiliates who work at the Hospital Businesses, including employees on approved leaves of absence as of the closing.

B. Buyer will offer the hired employees salaries and benefits packages that are comparable to their compensation packages at the time of closing.

C. Buyer will assume and honor ECHN's (and its Affiliates') collective bargaining agreements. Note that for Manchester Memorial Hospital these agreements currently extend through June 30, 2018 for registered nurses, May 31, 2017 for service and skilled maintenance employees, and June 30, 2017 for technical and LPN employees. For Rockville General Hospital, the collective bargaining agreement for registered nurses extends through December 31, 2018.

5. Key Assets and Liabilities to Be Acquired by Buyer

A. Buyer will acquire real property, leased property, equipment, accounts receivable, and net working capital (*i.e.*, non-cash current assets less the value of all current liabilities) of ECHN and the ECHN affiliates.

B. Key liabilities Buyer will assume include ECHN's unfunded pension liabilities, ECHN's health benefit plan for retirees, ECHN's captive insurer liabilities (*i.e.*, Connecticut Healthcare Insurance Company) and ECHN's workers' compensation obligations.

6. Key Assets and Liabilities Excluded from the Transaction

A. Buyer will exclude some current ECHN liabilities that will then remain the responsibility of ECHN's residual corporation following the transaction (note that this corporation will primarily serve administrative functions with respect to remaining assets).
   - For example, Buyer will exclude liabilities that could arise from lawsuits or tax settlements based on pre-closing activities.

B. Restricted assets of ECHN, *e.g.*, donor restricted funds held by the ECHN Community Healthcare Foundation, Inc., will be excluded from the transaction.

7. Purchase Price and Use of Proceeds

A. Buyer will pay $105,000,000 (subject to net working capital reconciliation), *minus* the book value of certain ECHN liabilities assumed by Buyer (*e.g.*, ECHN's unfunded pension obligations, "additional funding" of $8,000,000 that Buyer is requiring to assume the Captive Insurer Liability, "additional funding" of $3,450,000 that Buyer is requiring to assume the Workers' Compensation Liability), *minus* asbestos abatement liability of up to $1,000,000, and *minus*, in the event that ECHN is unable to assign or transfer to Buyer ECHN's interest in a joint venture, any amount ECHN receives from a third party to purchase ECHN's interest in such joint venture, or a dollar amount to be fixed in advance for each joint venture in the case that a joint venture interest remains with ECHN following the closing.

B. The proceeds from the asset sale will first be used to settle all of ECHN's bond liabilities and all of ECHN's other indebtedness.

C. Remaining proceeds will next be used to fund an indemnity reserve (the "Reserve") for a period of three years (the "Reserve Period") following the closing of the transaction for payment of ECHN liabilities that may arise post-closing. Any proceeds that remain after settling bond liabilities, settling other indebtedness, and funding the Reserve will be held by the residual ECHN corporation to be used for post-closing liabilities and wind down of operations.

D. After expiration of the Reserve Period (which may be extended in the event of claims arising during the Reserve Period), any funds remaining in the Reserve and not used to pay claims, would be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a community foundation and used to support charitable health related efforts in the wider ECHN community. Any donor restricted funds of ECHN (*e.g.*, restricted assets of the ECHN Community Healthcare Foundation, Inc.) would also likely be transferred to the community foundation designated by the Office of the Attorney General of the State of Connecticut.

8. Local Governance

A. Following the closing, Rockville General Hospital and Manchester Memorial Hospital will each maintain an advisory board of trustees (the "Local Board") made up of community representatives, physicians on the respective hospital's medical staff, and the Chief Executive Officer of the respective hospital.
   - The initial members of the Local Board shall include at least five members of ECHN's Board of Trustees immediately prior to the closing and five other individuals identified by ECHN prior to the closing.
   - Among other things, the Local Board will serve as a resource for Buyer with respect to Buyer's investment of the capital commitment described below, assist with maintenance and implementation of a strategic business plan for the hospitals, assume responsibility for medical

staff credentialing at the hospitals, maintain and oversee the quality assurance program at the hospitals and oversee and manage accreditation for the hospitals.

- For at least three years after the closing, Buyer will collaborate with the Local Board and remaining former hospital staff of ECHN on clinical quality matters to share best practices and establish clinical quality goals and measure progress.

9. Capital Commitment

A. Prior to the closing, Buyer, in consultation with ECHN and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses.

B. Buyer will commit to spend (or contract to spend) within five years of the closing not less than $75,000,000 (the "Commitment Amount") for the benefit of the Hospital Businesses and for the benefit of the communities surrounding Rockville General Hospital and Manchester Memorial Hospital (the "Hospitals"). These expenditures may include: (i) capital projects, including routine and non-routine capital expenditures for the improvement of ECHN's facilities; (ii) development, expansion, or acquisition of a department, program, service or facility; (iii) upgrades or renovations generally; (iv) deferred maintenance items; and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. For the purpose of determining whether the Commitment Amount has been satisfied, operating leases for (i) buildings or the fit-out or build-out of space used in the provision or support of medical services or (ii) medical equipment with a useful life of more than one year, shall count towards the Commitment amount.

- Buyer has the right to defer this commitment beyond a five year period if the State of Connecticut enacts any legal requirements after closing that discriminate against for-profit hospitals and cause the Hospital Businesses to suffer a decline in EBITDA of more than ten percent in any year on a consolidated basis. To the extent Buyer defers this commitment it shall make available to the public reasonably detailed information to support the Buyer's position and shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment.

10. Physician Alignment

A. Tenet and Yale-New Haven will form jointly a medical foundation in Connecticut of which Yale-New Haven (or a Yale-New Haven affiliate) will be the sole member. Tenet plans to provide funding for the medical foundation. The medical foundation will employ all licensed physicians employed by ECHN or its affiliates immediately prior to closing.

B. This medical foundation model is subject to legislative negotiations.

11. Role of Yale-New Haven

A. The Hospital Businesses will be designated as affiliates of Yale-New Haven after the closing.

B. Yale-New Haven will provide clinical expertise to the Hospital Businesses and will aid in comprehensive service line development.

C. As of February 2014, Tenet and Yale-New Haven have entered into a strategic affiliation.

12. Regulatory Approvals

A. Between the date of signing of the APA and the closing of the transaction, ECHN and Buyer will apply for all necessary regulatory approvals needed to consummate the transactions contemplated in the APA.
   - Among the regulatory approvals required are: (1) approval of the Connecticut Attorney General and the Commissioner of the Department of Public Health for conversion of the Hospital Businesses from non-profit to for-profit status; (2) certificate of need approval from the Connecticut Attorney General and the Commissioner of the Department of Public Health; and (3) antitrust clearance from the Federal Trade Commission.

13. Key Closing Conditions

A. Approval of transaction by ECHN Corporators.

B. No material adverse change to the business, assets, liabilities, financial condition or results of operations of ECHN.

C. Tenet and Yale-New Haven shall have formed a medical foundation in the State of Connecticut following successful legislative negotiations.

EASTERN CONNECTICUT HEALTH NETWORK
MANCHESTER MEMORIAL HOSPITAL
ROCKVILLE GENERAL HOSPITAL

MEETING MINUTES

MEETING: SPECIAL MEETING OF THE CORPORATORS

DATE: May 12, 2014 **LOCATION:** MMH HLR Auditorium **CONVENED:** 5:31 p.m. **ADJOURNED:** 6:29 p.m.

CORPORATORS PRESENT: D. Barry; L. Barry, PhD; R. Barry; M. Bars; E. Benavides; J. Bigman; R. Bissell; J. Breiter, MD; S. Breslau; C. Buchholz; J. Byrka; K. Chan, MD; N. Cullen; J. Daube, EdD; R. Dawson, III; M. Devanney; T. Devanney; R. Dimock; D. Downes, MD; H. Fitts; H. Haslett; K. Hudner; H. Igdalsky; W. Irish; S. Kassman; R. Kelley; A. Koenig; W. Kuenzler; N. Lahman; A. Lamson; R. Lefurge; S. Livingston; R. Luginbuhl; L. Lynch; A. Maneggia; S. Mason; T. Mason; M. McDonnell, MD; Rev. D. Miller; M. Miner; Chief M. Montminy; P. Moreschi; S. Naseer, MD; L. Pabst; R. Papa; H. Pastel, MD; M. Peracchio; T. Robinson; G. Roy; T. Scanlon; D. Skoczulek; M. Stoj, MD; L. Streeter; C. Vinick; D. Zubrow

TRUSTEES PRESENT: D. O'Neill, MD (Chair); G. Brodie, MD; T. Clemons; M. Conlon, MD; A. DiStefano, MD; J. Dorin; L. England; D. Genovesi; D. Gonci; R. Janenda; P. Karl; E. Kloter; R. Murdock-Meggers; K. O'Neill; L. Williams, MD

MANAGEMENT PRESENT: L. Crosskey; D. Gogliettino; S. Holmes; N. Kruse; L. Lemire; D. McConville; D. Parker; M. Powers; J. Reich, MD; T. Rose; J. Tichy; M. Veillette; C. Perigo (Recording Secretary)

GUESTS: J. Irvin; R. Irish; A. Ogilby

D. O'Neill, MD convened the meeting. On behalf of the ECHN Board of Trustees, he welcomed Corporators in attendance. He noted that after two and a half years of intensive research and negotiations by the Partnering Workgroup and the Transaction Committee the Board of Trustees unanimously approved the proposed transaction being presented. The public has had the opportunity to share their perspectives and now that legislators have shared their wisdom, ECHN finds itself ready to take the next step in ensuring the future of ECHN. He introduced Joy Dorin, Chair of the Transaction Committee.

1. Report from Transaction Committee Chair

DISCUSSION: J. Dorin, Chair of the Transaction Committee, introduced the other members of the Transaction Committee: David Gonci, Eric Kloter, Rebecca Janenda, Dennis O'Neill, MD and Peter Karl and asked that they stand and be recognized. She highlighted the processes undertaken to arrive at this point which began in December of 2011. The Partnering Workgroup was organized to proactively look at the challenges facing healthcare and how these challenges will affect eastern Connecticut. The focus has always been on preserving ECHN as a community healthcare system and as an important community asset. ECHN not only provides outstanding healthcare but also employs over 3000 people and makes significant economic contributions to this part of Connecticut we call home. The Transaction Committee (which was formed in April 2013 to review the work completed by the Partnering Workgroup, to evaluate the terms of a potential transaction and to make recommendations to the Board of Trustees) believes that it has negotiated the best possible future for ECHN. The Board of Trustees unanimously approved the Transaction Committee's recommendation that ECHN enter into an asset purchase agreement (APA) with Tenet Healthcare Corporation (THC) and Yale New Haven Health System (YNHHS) on April 9, 2014. This agreement will ensure that the mission and vision of ECHN will continue by protecting accessibility and affordability of care, enhancing quality and safety and providing clinical resources that will be expanded and strengthened by the investments made in the ECHN market by the THC/YNHHS joint venture. A press release with the Corporator voting results will be issued immediately following this meeting. Corporators were asked to direct any media inquiries to Nina Kruse, Vice President of Corporate Communications & Public Relations or to Dennis McConville, Sr. Vice President & Chief Strategy Officer. She introduced Peter Karl, President and CEO.

2. ECHN Challenges and Plans for the Future

DISCUSSION: P. Karl provided an overview of healthcare reform as reflected in the Patient Protection and Accountable Care Act (PPACA) and the impact it will have on ECHN. Calculations conducted in 2008 against current payor streams showed an $8,000,000 reduction in revenues due to payer mix changes expected under PPACA. He provided an overview of the other financial challenges. He noted that long term debt and pension liabilities have grown 97% in the last thirteen years due to the Pension Protection Act of 2006, market recession in 2008-2009 and facility and equipment upgrades. A capital needs assessment was conducted that will

require approximately $100,000,000 in revenues to cover the cost of annual replacement needs, facility and equipment upgrades and Electronic Medical Record (EMR) connectivity. Continued erosion in federal government payments, declining levels of payment from commercial payers and payment reforms with more financial risk, State hospital user tax and CMS 2% sequestration implementations, along with continued pension obligations and rising costs, will inevitability deplete ECHN's ability to reinvest in aging facilities or invest in new facilities and services.

A Partnering Workgroup made up of trustees, physicians, and management was developed in November 2012 to review the viability as a stand-alone system and the benefits of and vision for an affiliation. P. Karl shared the Workgroup's rationale for moving forward with the RFP process for a potential partner that would position ECHN as the "Provider of Choice" east of the river and ensure that both acute care hospitals and the post-acute care facility would remain open. By creating scale, improving access to capital and finances, and protecting, preserving and growing local access to services, ECHN could remain viable for the future. RFP's were sent to six (6) organizations in December 2013. Due to the combinations among the responders and one organization who dropped out, four (4) responses were received, three of which were joint proposals between not-for-profit andfor-profit entities. After thorough due diligence it was determined that the Tenet/Yale/ECHN strategic alliance would build a sustainable, thriving network of superior care. There had been some delays in the process due to the Governor's veto of Senate Bill-35, an act concerning notice of acquisitions, joint ventures and affiliation of group practices and hospital admissions, medical foundations and certificates of need, in 2013 that would allow membership by a for-profit in a medical foundation. The bill was revisited during the CT legislative sessions held February 5 through May 7, 2014 and was passed on May 7, 2014. ECHN held public hearings on April 29, 2104 at Rockville High School and on May 1, 2014 at Manchester Memorial Hospital to inform the community of the proposed transaction. Additional public forums may be required.

P. Karl provided an overview of the financial provisions. He noted that the remaining balance of the purchase price of $105,000,000 plus and minus numerous adjustments related to net working capital, capital leases, unfunded pension liabilities, post retiree health plan liabilities, captive insurance liabilities, workers' compensation liabilities, joint venture interests not conveyed, asbestos liabilities and long term debt would be the funding for a community foundation, which will be under the supervision of the Attorney General's (AG) Office. Duff & Phelps conducted a fairness opinion and has determined that the purchase price is "fair". He introduced Anne Ogilby, Ropes & Gray.

3. Highlights of the Asset Purchase Agreement (APA)

DISCUSSION: A. Ogilby, Ropes & Gray summarized the components of the APA. She reported that ECHN (which includes its subsidiaries) will be transferring all or substantially all of its assets to a THC/YNHHS joint venture. THC, a publicly traded company, will unconditionally guarantee all obligations under the APA. In addition to the cash price, the buyer has committed to maintaining the two acute care hospitals and the post-acute care facility for at least three years. This is a substantial period based on her experience, particularly in the current uncertain environment. The buyer has also committed to maintaining ECHN's residency and teaching programs and its current charity care policies, and has agreed to hire substantially all ECHN employees at comparable salaries and benefits. All collective bargaining agreements will also be honored, and the buyer has committed to assume all pension and captive insurance liabilities. THC/YNHHS will not be acquiring donor restricted funds or cash. The cash would be used to settle any remaining debt. An indemnity reserve will be established by ECHN to address any unexpected claims. The indemnity reserve will be maintained for three years, after which any residual funds will then be held by the community foundation in accordance with regulatory requirements. A local governing "Advisory" board will be created to oversee community matters related to safety and quality of care and capital expenditures. THC/YNHHS has made a substantial capital commitment of $75,000,000 to be utilized over a five year period for capital projects. YNHHS will provide clinical support to both of the hospitals and other clinical facilities. Clinical facilities will be branded as affiliates of YNHHS. A. Ogilby stated that the regulatory approval process is a long process that could take approximately nine months to one year. It is critical that ECHN continues to focus on day to day operations as there are conditions to closing related to operational and financial performance and regulatory approvals.

A. Ogilby provided an overview of the voting process. She stated that in accordance with the State of Connecticut statutes, two-thirds or 67% of the members entitled to vote and voting in person or by proxy need to approve the transaction. She further stated that proxies submitted by members who are present this evening are null and void. She introduced Dennis O'Neill, MD, Chair of the Board.

4. Presentation of Resolution for Approval

DISCUSSION: D. O'Neill, MD presented the Resolution for approval by the ECHN Corporators. A Corporator requested clarification about the role of the current Board of Trustees and the proposed Advisory Board. A. Ogilby stated that once ECHN sells to THC/YNHHS, the joint venture would become the operating entity that runs the community hospitals. THC and YNHHS have agreed that input from the local community is essential. THC has historically created a local "Advisory" board following acquisition. The current fiduciary Board would eventually be dissolved. The membership of the Advisory Board would be made up of ten members, five of whom would be selected by the current ECHN governing body and five selected by THC. Members would be made up of community representatives and term limitations may not be a requirement. A Corporator inquired about the feasibility of the three year commitment for the hospitals and clarification on the future role of Corporators. A. Ogilby stated that in her experience a three year commitment is favorable to ECHN given ECHN's smaller hospital status in a competitive market and in a tremendously uncertain healthcare environment. She also clarified that the three year commitment commences at the time of the closing and that the

buyer is subject to regulatory approvals to make any changes in the status of any entity thereafter. The authorities of the Corporators remain in effect until the transaction is completed, at which time, their terms will end.

A question and answer period followed regarding the utilization and status of donor funds. A community foundation will manage any charitable funds that remain following closing. The amount of the funds held by to the community foundation would be depend on the donor restricted fund balances, which currently total approximately $4,400,000, along with any residual portion of the purchase price, which will vary based on stock market performance, pension liability, and financial performance.

Following an explanation by D. O'Neill, MD on voting procedures, A. DiStefano, MD recused himself from voting.

A motion was made by S. Breslau, seconded by E. Kloter, and it was

ACTION: VOTED as follows;

WHEREAS, the Board of Trustees of Eastern Connecticut Health Network, Inc. (the "Corporation") has engaged in an extensive study of the health care market and future prospects and alternatives facing the Corporation; and

WHEREAS, after conducting such extensive study and considering the likelihood of continuing changes in the health care market and ongoing financial pressures, the Board of Trustees of the Corporation has negotiated that certain Asset Purchase Agreement by and among the Corporation and its affiliates pursuant to which substantially all of the assets of the Corporation and its affiliates will be sold to a limited liability company that is indirectly owned by Tenet Healthcare Corporation and Yale-New Haven Health Services Corporation (the "Asset Purchase Agreement"); and

WHEREAS, the Board of Trustees of the Corporation voted at its meeting of April 9, 2014 to approve the Asset Purchase Agreement as being in the best interest of the Corporation and its affiliates and to authorize the execution of the Asset Purchase Agreement by certain officers of the Corporation.

NOW, THEREFORE, be it resolved as follows:
RESOLVED: That the sale of substantially all the assets of the Corporation pursuant to the Asset Purchase Agreement is approved.

RESOLVED: That the President and CEO, Treasurer and Secretary of the Corporation be and they hereby are, and each of them acting singly is, hereby authorized from time to time, on behalf of the Corporation to take such other action as is necessary or desirable in connection with the transactions contemplated by the Asset Purchase Agreement.

During the tallying process D. O'Neill, MD referenced concerns that had been raised at the Public Forums about how THC/YNHHS would handle the underserved population in the MMH and RGH communities. He provided the historical background surrounding the establishment of the two hospitals in the early 1900's and their success in addressing the needs of the underserved population over time. It is anticipated that THC/YNHHS will care for the underserved population as both hospitals have for nearly 100 years.

The voting results were announced as follows:

In Person:	In favor: 64	Against: 5	Abstained: 0	Recused: 1
By Proxy:	In favor: 108	Against: 12	Abstained: 0	Recused: 0
Total:	**172**	**17**	**0**	**1**

A total of 190 votes were received by proxy and in person, of which 128 or 67% favorable votes were required for the transaction to pass by Connecticut Statute. The total percentage of votes in favor of the transaction was 91%.

D. O'Neill, MD thanked all who attended. The meeting was adjourned and Corporators were invited to the reception in the MMH CR A, B & C.

Respectfully Submitted

Chantal M. Perigo
Recording Secretary

Dennis G. O'Neill, MD
Chair

EXHIBIT 7 – CONFLICT OF INTEREST/DISCLOSURES - ECHN

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Gordon Brodie, MD

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

XX Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Board of Trustees

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

xx NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

xx NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

xx NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

xx NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

xx NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

xx NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

XX NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

XX NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

XX NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

XX NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Gordon Brodie, MD Digitally signed by Gordon Brodie, MD DN: cn=Gordon Brodie, MD, o, ou, email=oldemdrt@cox.net, c=US Date: 2014.10.20 18:15:26 -04'00'

Signature

10/14/2014

Date

Gordon Brodie, MD

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

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(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: THOMASINA CLEMONS

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): BOARD OF TRUSTEES, MEMBER

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): BOARD OF DIRECTOS, MEMBER

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

xxx NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

xxx NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

xxx NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

xxx NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

xxx NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

xxx NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

XXX NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

XXX NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

XXX NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

XXX NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Thomasina Clemons Digitally signed by Thomasina Clemons DN: cn=Thomasina Clemons, o, ou, email=tclemons655@comcast.net, c=US Date: 2014.10.06 07:58:42 -04'00'

Signature

10/6/2014

Date

THOMASINA CLEMONS, tclemons655@comcast.net

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michele Conlon M.D.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

__X__ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): member + Secretary

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

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__X__ NO _____YES. If YES, please provide details. _____

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__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Michele B Carlon MD
Signature

9-26-14
Date

Michele B Carlon MD
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Anthony J. DiStefano, M.D.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Board of Trustees, Chair, Department of Surgery

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

September 25, 2014
Date

Anthony J. DiStefano, M.D.
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Milton N. Doremus

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

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__X__ NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Milton N. Doremus
Signature

October 3, 2014 (mndjad@comcast.net)
Date

Milton N. Doremus
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Joy Watson Dorin

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

No — Expert or Consultant with:

Company Name: _____

Title: _____

Yes — Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Board member and committee member

Yes — ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board member

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

no NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

no NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

no NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

no NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

no NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

no NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

no NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

no NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

no NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

no NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joy Dorin Digitally signed by Joy Dorin DN: cn=Joy Dorin, o, ou, email=joyeaux@cox.net, c=US Date: 2014.09.29 08:05:54 -04'00'

Signature

September 25, 2014

Date

Joy Watson Dorin

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Louise C. England

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Trustee

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Louise C. England Digitally signed by Louise C. England DN: cn=Louise C. England, o, ou, email=lcengland@sbcglobal.net, c=US Date: 2014.10.14 13:59:43 -04'00'

Signature

10/14/14

Date

Louise C. England

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

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Please provide the following information:

Print Name: Donald S Genovesi

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

Sept. 25, 2014
Date

Donald S. Genovesi
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

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Please provide the following information:

Print Name: David H. Gonci

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

No financial interests known

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

No stock ownership known

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_____ NO X YES. If YES, please provide details. _____
Charitable donations to YNHHSC Entities not exceeding $1,000 per year

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

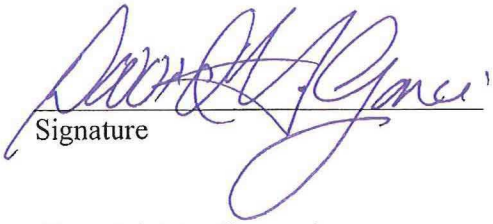
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. _____
Obtained routine medical services from YNHHSC Entities

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

October 7, 2014
Date

David H. Gonci
Printed Name

Conflict of Interest / Financial Disclosure Form

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(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: REBECCA D. JANENDA

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): TRUSTEE ECHN BOARD OF TRUSTEES

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

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__✓__ NO _____YES. If YES, please provide details. _____

_____

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__✓__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Rebecca D. Janenda
Signature

October 2, 2014
Date

REBECCA D. JANENDA
Printed Name

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Please provide the following information:

Print Name: Peter J. Karl

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): CEO

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board Member

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2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO x YES. If YES, please provide details. Employment and in order to ensure the retention of qualified staff necessary to complete the proposed Transaction, ECHN has committed to make a payment to me that is conditioned on my continued service up to and including the closing.

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

_____ NO x YES. If YES, please provide details. Local Board Member

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Employment and Local Board Position

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

09-25-14
Date

Peter J. Karl
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Eric L. Kloter

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: CINET
Title: Board of Trustees

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): Board of Trustees

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): Board of Trustees. Chairman

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

NO NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

NO NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

NO NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

NO NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

NO NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

NO NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

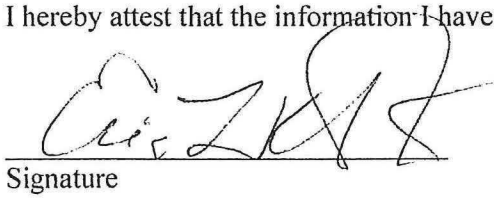
_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

September 29, 2014

Date

ERIC L. KLOTZ

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

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Please provide the following information:

Print Name: Pamela Lewis

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): President of medical staff

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Pamela L Lewis MD
Signature

10/15/14
Date

Pamela L Lewis
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1, **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Robin S. Murdock-Meggers

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

__X__ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

09/25/2014 12:28 FAX 860 645 8207 PMP&R,PC 0002/0005

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

09/25/2014 12:29 FAX 860 645 8207 RMPER,PC 0003/0005

Received fax : Sep 25 2014 12:40PM Fax Station : ECHN P. 3

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

09/25/2014 12:29 FAX 860 645 8207 PMPAR,PC 0004/0005

Received Fax : Sep 25 2014 12:40PM Fax Station : ECHN P. 4

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

September 25, 2014
Date

Robin S. Murdock-Meggers
Printed Name

09/25/2014 12:30 FAX 860 645 8207 FMPAR,PC 0005/0005

Received Fax : Sep 25 2014 12:40PM Fax Station : ECHN P. 5

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Kathleen A. O'Neill

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Kathleen A. O'Neill 9/25/14
Signature Date

Kathleen A. O'Neill
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

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   Please provide the following information:

   Print Name: DENNIS G O'NEILL MD

   Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

   _____ Expert or Consultant with:

   Company Name:_____

   Title: _____

   ___/___ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

   Position(s): CHAIR

   _____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

   Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9 25 14
Date

DENNIS C O'NEILL MD
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: LAURA S Williams

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

N/A Expert or Consultant with:

Company Name: _____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Board of Trustees

N/A ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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X NO ____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO ____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO ____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO ____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/15/14
Date

Laura S Williams
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

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(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Keith Wolff

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Board Member

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

___✓___ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

___✓___ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

___✓___ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

___✓___ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

___✓___ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

___✓___ NO _____ YES. If YES, please provide details. _____

_____

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✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/28/14

Keith Wolff
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Leona M. Crosskey

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Friends of Bolton Lakes Association
Title: President

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): VP Quality & Safety

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

NO NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

NO NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

NO NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

NO NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

NO NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

NO NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

NO NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Leona Crosskey Digitally signed by Leona Crosskey DN: cn=Leona Crosskey, o=ECHN, ou, email=lcrosskey@echn.org, c=US Date: 2014.10.02 09:52:21 -04'00'

Signature

10-2-2014

Date

Leona M. Crosskey

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Deborah R. Gogliettino

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): SVP/Chief Human Resource Officer

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO X YES. If YES, please provide details. _____

In order to ensure the retention of qualified staff necessary to complete the proposed Transaction, ECHN has committed to make a payment to me that is conditioned on my continued service up to and including the closing."

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____ YES. If YES, please provide details. _____

_____

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_____

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X NO _____ YES. If YES, please provide details. _____

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X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Deborah R. Gogliettino
Signature

10/6/14
Date

Deborah R. Gogliettino
Printed Name

Signature:

Email: cperigo@echn.org

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Nina Kruse

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: ECHN Community Healthcare Foundation, Inc.; Eastern Connecticut Health Network, Inc.

Title: Vice President of Development; Vice President of Corporate Communications & Public Affairs

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Vice President of Corporate Communications & Public Affairs

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO x YES. If YES, please provide details. _____

In order to ensure the retention of qualified staff necessary to complete the proposed Transaction, ECHN has committed to make a payment to me that is conditioned on my continued service up to and including the closing

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Digitally signed by Gordon Brodie, MD
DN: cn=Gordon Brodie, MD, o, ou, email=oldemdrt@cox.net, c=US
Date: 2014.10.08 12:07:48 -04'00'

Signature

10-8-14
Date

Nina Kruse
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Dennis P. McConville

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Senior Vice President, Chief Strategy Officer

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO __X__ YES. If YES, please provide details. In order to ensure the retention of qualified staff necessary to complete the proposed Transaction, ECHN has committed to make a payment to me that is conditioned on my continued service up to and including the closing.

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Dennis P. McConville Digitally signed by Dennis P. McConville DN: cn=Dennis P. McConville, o=ECHN, Inc., ou, email=dmcconville@echn.org, c=US Date: 2014.10.01 14:05:45 -04'00'

Signature

October 6, 2014

Date

Dennis P. McConville

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Deborah A. Parker

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Executive Vice President and Chief Clinical Officer

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__x__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__x__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__x__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Deborah A. Parker Digitally signed by Deborah A. Parker DN: cn=Deborah A. Parker, o=Eastern Connecticut Health Network, ou=Administration, email=dparker@echn.org, c=US Date: 2014.09.25 13:58:12 -04'00'

Signature

September 25, 2014

Date

Deborah A. Parker

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Mary Powers

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

MP Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Senior Vice President, Patient Care Services

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Mary Powers
Signature

09/25/14
Date

Mary Powers
Printed Name

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Joel J. Reich

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Chief Medical Officer/Sr. Vice President of Medical Affairs

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO X YES. If YES, please provide details. In order to ensure the retention of qualified staff necessary to complete the proposed transaction, ECHN has committed to make a payment to me that is conditioned on my continued service up to and including the closing.

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joel J Reich Digitally signed by Joel J Reich DN: cn=Joel J Reich, o=ECHN, ou=Medical Affairs, email=jreich@echn.org, c=US Date: 2014.10.06 22:34:08 -04'00'

Signature

10-05-14

Date

Joel J. Reich

Printed Name

Conflict of Interest / Financial Disclosure Form

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(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Edward J. Roberts

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Exec Director: ECPHO & CINECT

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Edward J. Roberts Digitally signed by Edward J. Roberts DN: cn=Edward J. Roberts, o=ECHN, ou=CINECT, email=erroberts@echn.org, c=US Date: 2014.10.15 09:29:08 -04'00'

Signature

October 14, 2014

Date

Edward J. Roberts

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Todd D. Rose

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): President & CEO of Visiting Nurse & Health Services of CT/ V.P. of Post Acute Care

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Todd D Rose Digitally signed by Todd D Rose DN: cn=Todd D Rose, o=Eastern Connecticut Health Network, ou=ECHN Post Acute Care, email=trose@ynhac.org, c=US Date: 2014.09.25 12:08:12 -04'00'

Signature

September 25, 2014

Date

Todd D Rose

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Joyce Tichy

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): General Counsel

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

_X_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_X_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO _X_ YES. If YES, please provide details. In order to ensure the retention of qualified staff necessary to complete the proposed Transaction, ECHN has committed to make a payment to me that is conditioned on my continued service up to and including the closing.

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

_X_ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

_X_ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

_X_ NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joyce Tichy Digitally signed by Joyce Tichy DN: cn=Joyce Tichy, o, ou=ECHN, email=jtichy@echn.org, c=US Date: 2014.10.06 16:35:51 -04'00'

Signature

October 6, 2014

Date

Joyce Tichy

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michael D. Veillette

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Chief Financial Officer

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Chief Financial Officer

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO X YES. If YES, please provide details. _____

In order to ensure the retention of qualified staff necessary to complete the proposed Transaction, ECHN has commited to make a payment to me that is conditioned on my continued service up to and including the closing

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details.. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Michael D. Veillette Digitally signed by Michael D. Veillette DN: cn=Michael D. Veillette, o, ou, email=mveillette@echn.org, c=US Date: 2014.10.13 09:55:38 -04'00'

Signature

October 13, 2014

Date

Michael D. Veillette

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

   (a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

   Please provide the following information:

   Print Name: Gregory M. Williams

   Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

   X Expert or Consultant with:
   Company Name: Medical Practice Partners, LLC
   Title: President

   X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
   Position(s): Senior Vice President, Network Services

   _____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
   Position(s): _____

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. On behalf of Eastern CT Medical Professionals, Inc., we entered into a professionals services contract with Yale Medical Group to provide vascular services in our community.

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. Acquired services noted in ii above.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9-25-14
Date

Gregory M. Williams
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Richard G. Bundy JR.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

N/A Expert or Consultant with:
Company Name: _____
Title: _____

N/A Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Member Board of Directors

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

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✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Richard G Bundy Jr
Signature

9/26/2014
Date

Richard G Bundy JR.
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: David A. Engelson

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice Chair

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

David A. Engelson
Signature

10/10/14
Date

David A. Engelson
Printed Name

JRT

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: JOANNE RENEE IRVIN

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): CONTRACTING COMMITTEE

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

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__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/1/14
Date

JOANNE RENEE IRVIN
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: DONALD G. MILLER

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Trustee

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Donald G. Miller — Signature

Oct. 16, 2014 — Date

DONALD G. MILLER — Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

   (a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Americo Rodrigues

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board of Trustees Member

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

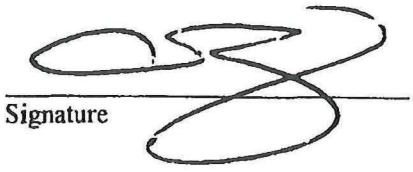
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

9/25/14
Date

Americo Rodrigues
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Kathleen A. Stavens

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Corporator

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Treasurer, Board of Director, Chair Finance/Investment Committee

(b) Please complete and return this Disclosure Form no later than October 10, 2014 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Kathleen A. Stavens Digitally signed by Kathleen A. Stavens DN: cn=Kathleen A. Stavens, o, ou, email=kathrinkestavens@att.net, c=US Date: 2014.09.25 13:00:33 -04'00'

Signature

9/25/2014

Date

Kathleen A. Stavens

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Catherine P. Collette

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice President Quality Assurance, Visiting Nurse and Health Services of CT

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Catherine P. Collette Digitally signed by Catherine P. Collette DN: cn=Catherine P. Collette, o=Easter Connecticut Health Network, ou=Visiting Nurse and Health Services of CT, email=cpcollette@ynhsc.org, c=US Date: 2014.09.25 13:24:03 -04'00'

Signature

09/25/2014

Date

Catherine P. Collette RN MSN

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Janet Gallugi

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

*_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice President of Business Development

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

*_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

*_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

*_____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

*_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

*_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

*_____ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

*

_____ NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

*

_____ NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

*

_____ NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

*

_____ NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Janet Gallugi
Signature

10/06/10
Date

Janet Gallugi
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Paul Golino

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Controller

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 10/10/14

Paul Golino
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Rosemary Harding

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice President Clinical Services

(b) Please complete and return this Disclosure Form no later than October 10, 2014 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

XX NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Rosemary Harding
Signature

09/25/2014
Date

Rosemary Harding
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Christine McGuire

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Chief Financial Officer Visiting Nurse & Health Services of CT, INC and A Caring Hand

(b) Please complete and return this Disclosure Form no later than October 10, 2014 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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2. **Definitions:**

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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X NO _____ YES. If YES, please provide details. _____

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X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

C M McGuire
Signature

9/25/14
Date

Christine McGuire
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Mary Coleman-McNamara

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice President, Human Resources

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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_____

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Mary Coleman-McNamara
Signature

09/25/2014
Date

Mary Coleman-McNamara
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Katherine Mon

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Executive Director

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Katherine Mon
Signature

10-10-14
Date

Katherine Mon
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Dianne Welch

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Director of Hospice and Palliative Care

(b) Please complete and return this Disclosure Form no later than October 10, 2014 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Dianne Welch
Signature

Sept. 25, 2014
Date

Dianne Welch
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Robert Anthony

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: Brown Rudnick
Title: Attorney

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. Brown Rudnick provided legal services to Yale New Haven Hospital (unrelated to the Transaction)

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO ✓ YES. If YES, please provide details. Brown Rudnick provided legal services to Yale New Haven Hospital (unrelated to the Transaction)

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Robert J. Anthony
Signature

10/14/2014
Date

Robert J. Anthony
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Karen M. Banoff

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: KMB Consulting, LLC
Title: Principal

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than October 10, 2014 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO x YES. If you answered YES, please note the name of the entity and income generated from the entity. KMB Consulting, LLC provides consulting services to YNHHSC

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO x YES. If YES, please provide details. _____
Payment for consulting services

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. _____
KMB Consulting, LLC provides consulting services to YNHHSC

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. _____

Furnished consulting services to YNHHSC

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Karen M. Banoff
Signature

9/25/14
Date

Karen M. Banoff
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Jonathan Barry

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Mercer
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

October 14, 2014
Date

Jonathan Barry
Printed Name

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Please provide the following information:

Print Name: Aaron S. Bayer

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. Through Wiggin and Dana LLP, I provide legal services from time to time to YNHHSC and its affiliates. Wiggin and Dana LLP is not a "Related Person" as defined herein.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

October 13, 2014
Date

Aaron S. Bayer
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: David H. Blackwell

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Blackwell & Spadaccini, LLC
Title: Attorney

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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3. **Financial Interests:**

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__x__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__x__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO __x__ YES. If YES, please provide details. Blackwell & Spadaccini, LLC will render transactional legal services to ECHN at a future date.

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__x__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

David H. Blackwell Digitally signed by David H. Blackwell DN: cn=David H. Blackwell, o=Blackwell & Spadaccini, LLC, ou, email=dblackwell@eastcenterlaw.com, c=US Date: 2014.09.25 17:43:48 -04'00'

Signature

September 25, 2014

Date

David H. Blackwell

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Cody R. Braithwaite, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Attorney

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

_x____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_x____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

_x____ NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Cody R. Braithwaite
Signature

October 9, 2014
Date

Cody R. Braithwaite
Printed Name

cbraithwaite@hselaw.com

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Leslie E. DesMarteau, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: ERISA Counsel

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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3. **Financial Interests:**

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_x____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_x____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

_x____ NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Leslie E. DesMarteau
Signature

October 9, 2014
Date

Leslie E. DesMarteau
Printed Name

ldesmarteau@hselaw.com

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Please provide the following information:

Print Name: Thomas J. Hurley, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Attorney (Partner)

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

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_x____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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_x____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Thomas J. Hurley
Signature

October 9, 2014
Date

Thomas J. Hurley
Printed Name

thurley@hselaw.com

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Please provide the following information:

Print Name: Lisa G. Pelta, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: ERISA Counsel

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Lisa G. Pelta
Signature

October 8, 2014
Date

Lisa G. Pelta
Printed Name

lpelta@hselaw.com

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

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Please provide the following information:

Print Name: Joseph E. Simpson, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: ERISA Counsel

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

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(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joseph E. Simpson
Signature

October 8, 2014
Date

Joseph E. Simpson
Printed Name

jsimpson@hselaw.com

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Please provide the following information:

Print Name: Lori J. Stone, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: ERISA Counsel

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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_x____ NO _____YES. If YES, please provide details. _____

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_____

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X NO _____ YES. If YES, please provide details. _____

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X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Lori J. Stone
Signature

October 8, 2014
Date

Lori J. Stone
Printed Name

lstone@hselaw.com

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Please provide the following information:

Print Name: Mark R. Wilson, Esq.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Attorney (Partner)

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Mark R. Wilson
Signature

October 9, 2014
Date

Mark R. Wilson
Printed Name

mwilson@hselaw.com

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Please provide the following information:

Print Name: Mary C. Connor

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: The Chartis Group
Title: Associate Consultant

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/1/14
Date

Mary C. Connor
Printed Name

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Please provide the following information:

Print Name: Melinda A. Agsten

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
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X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. See response to 4(c)(iv) below.

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. Through Wiggin and Dana LLP, I provide legal services from time to time to YNHHSC and its affiliates. Wiggin and Dana LLP is not a "Related Person" as defined herein.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Melinda A. Agsten
Signature

October 13, 2014
Date

Melinda A. Agsten
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Rebecca A. Matthews

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
See response to 4(c)(iv) below.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. _____

Through Wiggin and Dana LLP, I provide legal services from time to time to YNHHSC and its affiliates. Wiggin and Dana LLP is not a "Related Person" as defined herein.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

October 13, 2014
Date

Rebecca A. Matthews
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Adam Eckart

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Ropes & Gray LLP
Title: Associate

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

aeckart@ropesgray.firm Digitally signed by aeckart@ropesgray.firm DN: cn=aeckart@ropesgray.firm Date: 2014.10.14 15:01:29 -04'00'

Signature

10/14/14

Date

Adam Eckart

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Merton G. Gollaher

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

See response to 4(c)(iv) below.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. _____

Through Wiggin and Dana LLP, I provide legal services from time to time to YNHHSC and its affiliates. Wiggin and Dana LLP is not a "Related Person" as defined herein.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

October 16, 2014

Date

Merton G. Gollaher

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michael McDonough

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Murtha Cullina LLP
Title: Partner / Executive Committee Member

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): I am a Corporator but not a board member of ECHN

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO __X__ YES. If you answered YES, please note the name of the entity and income generated from the entity. We do some legal work for (primarily immigration) YNHHSC entities - we have conflict waivers from both Yale on ECHN from 12/1/11 we have been paid the amounts listed on Ex. B

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO __X__ YES. If YES, please provide details. As legal counsel for certain aspects of the transaction

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____ YES. If YES, please provide details. other than as disclosed above

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO __X__ YES. If YES, please provide details. see above

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date _____

Michael McDonough
Printed Name

Conflict of Interest / Financial Disclosure Form

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(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Anne Ogilby

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:

Company Name: Ropes & Gray LLP

Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity. Ropes & Gray does not represent Tenet or YNHHSC. Ropes & Gray does represent Greenwich Hospital, a YNHHSC affiliate, on an unrelated matter. Ropes & Gray's relationship with all clients is subject to all applicable legal ethics requirements, and the firm maintains a robust conflict management system.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____ YES. If YES, please provide details. Ropes & Gray may invest in mutual funds or other investment funds that own stock.

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

x NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/15/2014
Date

Anne Ogilby
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: David Peloquin

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:

Company Name: Ropes & Gray LLP

Title: Associate

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity. Ropes & Gray does not represent Tenet or YNHHSC. Ropes & Gray does represent Greenwich Hospital, a YNHHSC affiliate, on an unrelated matter. Ropes & Gray's relationship with all clients is subject to all applicable legal ethics requirements, and the firm maintains a robust conflict management system.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____ YES. If YES, please provide details. Ropes & Gray may invest in mutual funds or other investment funds that own stock.

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

x _____ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

x _____ NO _____ YES. If YES, please provide details. _____

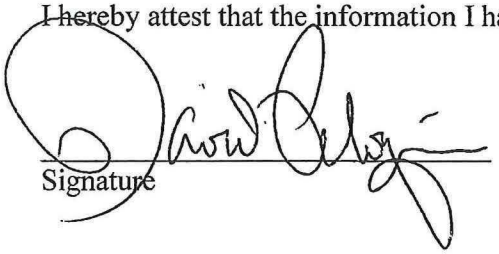
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

x _____ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

x _____ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

10/15/2014

Date

David Peloquin

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Robert Christopher Regan

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: The Charles Group
Title: Managing Director

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than October 10, 2014 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__N/A__ NO __✓__ YES. If you answered YES, please note the name of the entity and income generated from the entity. The Chabris Group has worked as a Consultant to Vanguard Health in its corporate office and for Children's Michigan in Detroit in 2013. Total value of contract $80,000.-

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/27/14

R. Chris Regan
Printed Name

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Raphe Schwartz

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: The Chartis Group, LLC
Title: Director

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than [illegible] to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO ✓ YES. If you answered YES, please note the name of the entity and income generated from the entity. The Charnis Group worked for Vanguard Health in its corporate office and for Children's Michigan in Detroit in 2013. Total value of all consulting services for Charnis was approximately $780,000.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/29/2014

Raphe Schwartz
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: LOUIS A. SPADACCINI

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: BLACKWELL SPADACCINI, LLC
Title: ATTORNEY, MEMBER

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO __X__ YES. If YES, please provide details. BLACKWELL SPANGLER, LLC WILL PROVIDE LEGAL SERVICES TO ECHN IN CONNECTION WITH THE TRANSACTION

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

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__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ 10/10/14

Signature Date

LOUIS A. SPADACCINI

Printed Name

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Please provide the following information:

Print Name: Sara Vaezy

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: The Chartis Group, LLC
Title: Consultant

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__x__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO __x__YES. If you answered YES, please note the name of the entity and income generated from the entity. The Chartis Group has worked as a consultant for Vanguard Health in its corporate office and for Children's Michigan in Detroit in 2013. Total value of the contract ~$780,000

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__x__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__x__ NO _____YES. If YES, please provide details. _____

_____

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

09/30/2014
Date

Sara Vaezy
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Marjorie Lessman Fisher

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board member

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

_✓_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_✓_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

_✓_ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Marianne Lassonde Fisher 10/21/2014

Signature Date

Marianne Lassonde Fisher

Printed Name

EXHIBIT 8 – CONFLICT OF INTEREST/DISCLOSURES - TENET

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of Tenet who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jeffrey M. Peterson

(b) Please complete and return the Disclosure Form no later than **October 21, 2014** to Collin Baron, 850 Main Street, Bridgeport, CT 06604 or cbaron@pullcom.com. If you have any questions regarding the Disclosure Form, please contact Collin Baron at 203-330-2219.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. Definitions:

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A

Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

_X_ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

_X_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_X_ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

_X_ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_____ NO _X_ YES. If YES, please provide details. If the transaction is completed, I may serve as a director of any wholly owned first subsidiaries in the chain of ownership of ECHN (uncompensated role)

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/20/14
Date

Jeffrey M Peterson
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by certain senior executives of Tenet who have direct involvement in the Transaction.

Please provide the following information:

Print Name: HAROLD H. PILGRIM, III

(b) Please complete and return the Disclosure Form no later than **October 21, 2014** to Collin Baron, 850 Main Street, Bridgeport, CT 06604 or cbaron@pullcom.com. If you have any questions regarding the Disclosure Form, please contact Collin Baron at 203-330-2219.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A

Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__✓__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__✓__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/20/14
Date

H. PILGRIM
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of Tenet who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Keith B. Pitts

(b) Please complete and return the Disclosure Form no later than **October 21, 2014** to Collin Baron, 850 Main Street, Bridgeport, CT 06604 or cbaron@pullcom.com. If you have any questions regarding the Disclosure Form, please contact Collin Baron at 203-330-2219.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

_X_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

_X_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_X_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

_X_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_X_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

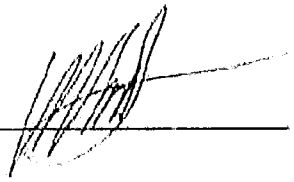
(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

10/20/14
Date

Keith B. Pitts
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by certain senior executives of Tenet who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Wilson Robinson

(b) Please complete and return the Disclosure Form no later than **October 21, 2014** to Collin Baron, 850 Main Street, Bridgeport, CT 06604 or cbaron@pullcom.com. If you have any questions regarding the Disclosure Form, please contact Collin Baron at 203-330-2219.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/20/2014
Date

Wilson Robinson
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of Tenet who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Erik G. Wedlar

(b) Please complete and return the Disclosure Form no later than **October 17, 2014** to Colin Baron, 850 Main Street, Bridgeport, CT 06601 or cbaron@pullman.com. If you have any questions regarding the Disclosure Form, please contact Colin Baron at 203-330-2219.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__X__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__X__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 10/19/14

Erik G. Wexler
Printed Name

EXHIBIT 9 – TENET HEALTHCARE CORPORATION CORPORATE GOVERNANCE PRINCIPLES

TENET HEALTHCARE CORPORATION
CORPORATE GOVERNANCE PRINCIPLES

The Board of Directors of Tenet Healthcare Corporation, acting on the recommendation of its Nominating and Corporate Governance Committee, has developed and adopted a set of corporate governance principles to promote a common set of expectations as to how the Board and its committees should perform their functions. These principles will be published on Tenet's corporate website and reviewed by the Board annually or more often as the Board deems appropriate.

1. **Role of Board and Management.** Tenet's business is conducted by its employees, managers and officers, under the direction of its Chief Executive Officer to enhance Tenet's long-term value for its shareholders. The Board is elected by the shareholders to oversee management and to monitor whether the long-term interests of the shareholders are being served. Both the Board and management recognize that the long-term interests of shareholders are advanced by responsibly addressing the concerns of other stakeholders and interested parties including patients, employees, physicians who practice at hospitals owned by Tenet's subsidiaries, lenders, bondholders, communities in which Tenet and its subsidiaries' hospitals do business, legislators, regulators and other government officials and the public at large.

2. **Board Committees.** The Board has established the following Committees to assist it in discharging its responsibilities: (i) Audit, (ii) Compensation, (iii) Nominating and Corporate Governance, (iv) Quality, Compliance and Ethics, and (v) Executive. Each Committee except the Executive Committee has a charter setting forth the key responsibilities of the Committee. Each Committee's charter is published on Tenet's corporate website and establishes independence standards for its members and is reviewed at least annually. Each Committee has a Chairperson who is nominated by the Nominating and Corporate Governance Committee and elected by the Board each year. Each Committee Chairperson reports the highlights of the meetings of his/her Committee to the full Board following each Committee meeting.

3. **Functions of the Board and its Committees.** Members of the Board and each Committee meet in person for regularly scheduled meetings and hold as many additional telephonic and in-person meetings as necessary to fulfill their responsibilities. At the Board and Committee meetings, Tenet's directors review, discuss, evaluate and ask questions of management and Board and Committee advisors concerning reports by management on Tenet's business strategy and long-term goals; financial and operating performance; financial condition; prospects, including competitive challenges and opportunities; and compliance and litigation. On at least an annual basis, the Board reviews its role and the roles of its Committees in the risk oversight of the Company. The Board and Committees also:

- Review, approve and monitor major corporate actions;
- Select the CEO and oversee the selection of Tenet's other executive officers;
- Evaluate and compensate Tenet's executive officers;

- Evaluate and approve a CEO succession plan;
- Assess major risks facing Tenet and review options for their mitigation;
- Monitor the integrity of Tenet's accounting, financial reporting and finance processes and systems of internal controls; and
- Review and monitor the processes in place for maintaining Tenet's ethical conduct, the quality of care provided at hospitals owned by Tenet's subsidiaries and compliance with laws and regulations.

4. **Size of Board and Selection Process.** The Nominating and Corporate Governance Committee is responsible for recommending, and the Board is responsible for selecting, the individuals to stand for election at each annual meeting. The Nominating and Corporate Governance Committee is also responsible for recommending, and the Board is responsible for selecting, the individuals to fill vacancies on the Board. Shareholders also may propose nominees for election to the Board in accordance with Tenet's Bylaws, which may be found on Tenet's website. Tenet's Bylaws require that Tenet have between 8 and 15 directors with the exact number set by the Board.

The Nominating and Corporate Governance Committee and the Board consider, among other things, the following attributes and criteria when selecting new nominees for election to the Board and determining which of Tenet's existing directors will stand for re-election to the Board: experience, skills, expertise, diversity, personal and professional integrity, character, business judgment, time availability in light of other commitments, dedication, conflicts of interest and such other factors as the Board considers appropriate in the context of its needs.

5. **Director Qualifications and Expectations.** Incumbent directors are not automatically re-nominated to stand for election. Each year, the Nominating and Corporate Governance Committee and Board will carefully consider each director's qualifications and contributions to the Board and make an informed decision as to which directors will stand for election.

Tenet's directors receive, and are expected to review, Board and Committee materials from management and the Board's and Committees' independent advisors in advance of all meetings. Directors are expected to attend all meetings of the Board and all meetings of the Committees on which they serve, and they are required to attend at least 75% of all regularly scheduled Board and Committee meetings.

Directors who serve as CEOs or in equivalent positions of public companies may not serve on the boards of more than two public companies in addition to Tenet's Board, and other directors may not serve on the boards of more than three public companies in addition to Tenet's Board. At the request of a director, the Chair of the Nominating and Corporate Governance Committee may waive the three board limit for a non-CEO director in a particular situation, upon a showing that additional board service would not impair the director's service on the Tenet Board.

No two Tenet directors may serve together on the board of any public company other than Tenet. Directors are expected to offer their resignation in the event of any significant change in their principal job responsibilities.

6. **Independence of Directors.** Two-thirds of the Board will consist of "independent" directors. The Board will not consider a director to be independent unless the Board affirmatively determines that the director has no material relationship with Tenet, and the director otherwise qualifies as independent under the corporate governance standards of the New York Stock Exchange.

7. **Independence of Committee Members.** The members of the Audit, Compensation and Nominating and Corporate Governance Committees shall meet the independence standards of the NYSE. In addition, the members of the Audit Committee shall meet the SEC independence standards for audit committee members.

8. **Non-Executive Chairman or Lead Director.** The Board will designate an independent, non-employee director as Chairman of the Board or, in the event that the Board desires to elect a member of management or a non-independent director to the Board and to appoint such individual as Chairman of the Board, the independent directors of the Board will designate an independent, non-employee director as Lead Director. The Lead Director will have a term of at least one year. The duties of the Lead Director will include, but not be limited to, (i) presiding at all meetings of the Board at which the Chairman is not present, (ii) chairing executive sessions of the Board, (iii) serving as the liaison between the independent directors and the Chairman, (iv) approving the information sent to the Board and meeting agendas and schedules, (v) having the authority to call meetings of the independent directors and (vi) representing the Board in meetings with investors, legislators, regulators and other government officials. The Lead Director, in conjunction with the Nominating and Corporate Governance Committee, also will take a role in the Board performance evaluation process.

9. **Executive Sessions.** Following every regularly scheduled Board meeting and at least once each fiscal quarter, the independent directors of the Board will meet in executive session without management present and, in the event there is an executive Chairman, the Lead Director will preside at such meetings. The independent directors may meet in executive session at such other times as determined by the Chairman and/or Lead Director. The Committees of the Board shall meet in executive session as prescribed in each Committee's charter. Each Committee of Tenet's Board regularly meets in executive session.

10. **Board Performance Evaluation.** The Nominating and Corporate Governance Committee will conduct an annual performance evaluation to determine whether the Board, its Committees and individual directors are functioning well in view of their responsibilities and Tenet's business. The results of the evaluation will be reviewed by the Chairman and/or the Lead Director who will report the results to the Board. As part of the annual performance evaluation process, each Committee will compare its performance with the requirements of its charter.

11. **Ethics and Conflicts of Interest.** The Board expects the directors, as well as all officers and other employees, to act ethically at all times and to acknowledge their

adherence to the policies comprising Tenet's *Standards of Conduct*. If an actual or potential conflict of interest arises for a director, the director shall promptly inform the Chairman of the Board and/or the Lead Director. If a significant conflict exists and cannot be resolved, the director should resign. All directors will recuse themselves from any discussion or decision affecting their personal, business or professional interests. The Quality, Compliance and Ethics Committee shall resolve any conflict of interest question involving directors or executive officers.

12. Reporting Concerns to the Audit Committee. Anyone who has a concern about Tenet's conduct, or about its accounting, internal accounting controls or auditing matters, may communicate that concern to the Audit Committee by calling Tenet's Ethics Action Line at 1-800-8-ETHICS (1-800-838-4427). Such communications may be confidential or anonymous. All such concerns will be forwarded to the Audit Committee for its review and will be simultaneously reviewed and addressed under the direction of Tenet's Chief Compliance Officer. The Audit Committee may direct special treatment, including the retention of outside advisors, for any concern addressed to it. Tenet's *Standards of Conduct* prohibit any employee from retaliating or taking any adverse action against anyone for raising or helping to resolve an ethical concern.

13. Shareholder Communications with the Board. Shareholders may communicate with the Board by e-mail to *boardofdirectors@tenethealth.com* or by writing to the Board c/o Corporate Secretary at Tenet's Dallas headquarters. Shareholder communications will be reviewed internally if the shareholder's concern can best be addressed by referral to a Tenet department such as Investor Relations or Corporate Communications. All other communications will be referred to the Corporate Secretary, who will determine if the communication should be brought to the attention of the full Board, the Chairman of the Board or a particular Board committee or Board member.

14. Compensation of Board. The Compensation Committee will conduct a review at least once every two years of the components and amount of Board compensation in relation to other similarly situated companies and make a report to the Board. Board compensation will be consistent with market practices and will be set at a level that does not call into question the Board's objectivity.

15. Stock Ownership and Retention Requirements. Each Tenet director with more than one year of service on the Board is required to own shares of Tenet's common stock. In addition, each director is required within five years of becoming a member of the Board, to own shares of Tenet's common stock with a market value equal to five times the director's annual retainer. Each of Tenet's senior officers is required to own shares of Tenet's common stock with a market value equal to a specific multiple of such senior officer's base salary as indicated in the table below. Each senior officer must meet the stock ownership requirements within five years from the date on which he or she becomes a senior officer. If, during or after such five-year period, a senior officer is promoted to a position that requires a higher stock ownership multiple than the position previously held, the senior officer will be granted an additional two-year period to meet the increased multiple.

Executive Level	Market Value of Common Stock Owned as a Multiple of Base Salary
Chief Executive Officer	6x
President	4x
Executive Vice President/Others above SVP	2x
Senior Vice President	1x

Shares counted toward the director and senior officer stock ownership requirements include: (i) shares of common stock held of record or in a brokerage account by the individual or his or her spouse; (ii) restricted stock or restricted stock units; (iii) stock units issued under deferred compensation plans; and (iv) any other security designated by Tenet's Nominating and Governance Committee as counting toward the guidelines.

If a director or senior officer does not meet the applicable ownership requirements, he or she must retain and hold 100% of any "net shares" received upon the exercise of stock options and the vesting of restricted stock or restricted stock units until such time as the director or senior officer meets such requirements. For purposes of this section, "net shares" means the number of shares received upon exercise of stock options or upon vesting of restricted stock or restricted stock units less the number of shares sold or deducted to pay the exercise price (in the case of options), withholding taxes and any brokerage commissions.

16. **CEO Evaluation; Succession Plan.** At least annually, the Board will conduct an evaluation of the CEO and review a succession plan for the CEO.

17. **Contact with Management and Operations.** All directors are encouraged to contact the CEO and other members of management at any time to discuss any aspect of Tenet's business. The Board will have frequent opportunities for directors to meet with the CEO and other members of management in Board and Committee meetings and in other formal and informal settings. Directors are expected to visit at least one Tenet hospital each year.

18. **Access to Independent Advisors.** The Board and its Committees have the authority and the funding to retain, at any time, independent outside financial, legal or other advisors. All such advisors are chosen by, and report directly to, the Board or the respective Committee.

19. **Director Retirement.** Directors will not be nominated for election to the Board after their 75th birthday.

20. **Majority Voting Policy.** Tenet's Bylaws provide for majority voting in the uncontested election of directors and plurality voting in contested elections. In uncontested elections, directors are elected by a majority of the votes cast, which means that the number of shares voted "for" a director must exceed the number of shares voted "against" that director. The Nominating and Corporate Governance Committee has established procedures for any director who is not elected to tender his or her resignation. The Nominating and Corporate Governance Committee will recommend to the Board whether to accept or reject the resignation offer, or whether other action should be taken.

In determining whether to recommend that the Board accept any resignation offer, the Nominating and Corporate Governance Committee will be entitled to consider all factors believed relevant by the Committee's members. The Board will act on the Nominating and Corporate Governance Committee's recommendation within ninety (90) days following certification of the election results. In deciding whether to accept the resignation offer, the Board will consider the factors considered by the Nominating and Corporate Governance Committee and any additional information and factors that the Board believes to be relevant. Thereafter, the Board will promptly publicly disclose its decision regarding the director's resignation offer (including the reason(s) for rejecting the resignation offer, if applicable). If the Board accepts a director's resignation offer pursuant to this process, the Nominating and Corporate Governance Committee will recommend to the Board and the Board will thereafter determine whether to fill such vacancy or reduce the size of the Board. Any director who tenders his or her resignation pursuant to this provision will not participate in the proceedings of either the Nominating and Corporate Governance Committee or the Board with respect to his or her own resignation offer.

21. **Director Orientation.** New directors participate in an orientation process. That orientation process will include background materials on Tenet, its business, strategic plans and goals, prospects and risk profile, and meetings with senior management.

22. **Continuing Education.** Each director is expected to attend a continuing education program related to their responsibilities as a director at least once every two years.

23. **Amendment.** These corporate governance principles shall not be amended except upon the approval of a majority of Tenet's independent Board members or as otherwise required by law or regulation.

EXHIBIT 10 – CONFLICT OF INTEREST/DISCLOSURES - YNHHS

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Richard D'Aquila

(b) Please complete and return the Disclosure Form no later than October 17, 2014 to William J. Aseltyne, [insert address] or Bill. Aseltyne@ynhh.org. If you have any questions regarding the Disclosure Form, please contact William Aseltyne at [insert phone].

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.


Signature

10/13/14
Date

Richard D'Aguila
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: James Stanley

(b) Please complete and return the Disclosure Form no later than **October 17, 2014** to William J. Aseltyne, [insert address] or Bill. Aseltyne@ynhh.org. If you have any questions regarding the Disclosure Form, please contact William Aseltyne at [insert phone].

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

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✓ NO _____ YES. If YES, please provide details. _____

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✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

James Staten
Signature

10-12-14
Date

James Staten
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: William J. Aseltyne

(b) Please complete and return the Disclosure Form no later than **October 17, 2014** to William J. Aseltyne, [insert address] or Bill. Aseltyne@ynhh.org. If you have any questions regarding the Disclosure Form, please contact William Aseltyne at [insert phone].

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

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(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

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_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

Y NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

Y NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

Y NO _____YES. If YES, please provide details. _____

_____

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(ii) Leased assets to or leased assets from an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

W. J. A

Signature

10/13/14

Date

William J. Applegate

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Gayle Capozzalo

(b) Please complete and return the Disclosure Form no later than **October 17, 2014** to William J. Aseltyne, [insert address] or Bill. Aseltyne@ynhh.org. If you have any questions regarding the Disclosure Form, please contact William Aseltyne at [insert phone].

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_____ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

_____ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/13/2024
Date

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

1. Instructions:

(a) This Disclosure Form is to be completed by certain senior executives of YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Marna P. Borgstrom

(b) Please complete and return the Disclosure Form no later than **October 17, 2014** to William J. Aseltyne, [insert address] or Bill. Aseltyne@ynhh.org. If you have any questions regarding the Disclosure Form, please contact William Aseltyne at [insert phone].

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

14 October 2014
Date

Marna P. Borgstrom
Printed Name

EXHIBIT 11 – DUFF & PHELPS' QUALIFICATIONS AND CONFLICT DISCLOSURE



ECHN

Fairness Opinion and Healthcare Experience and Qualifications

October 2013

DUFF & PHELPS

Table of Contents

Sections

1. Healthcare Practice Overview
2. Overview of Duff & Phelps
3. Professional Biographies

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Section 1

Healthcare Practice Overview

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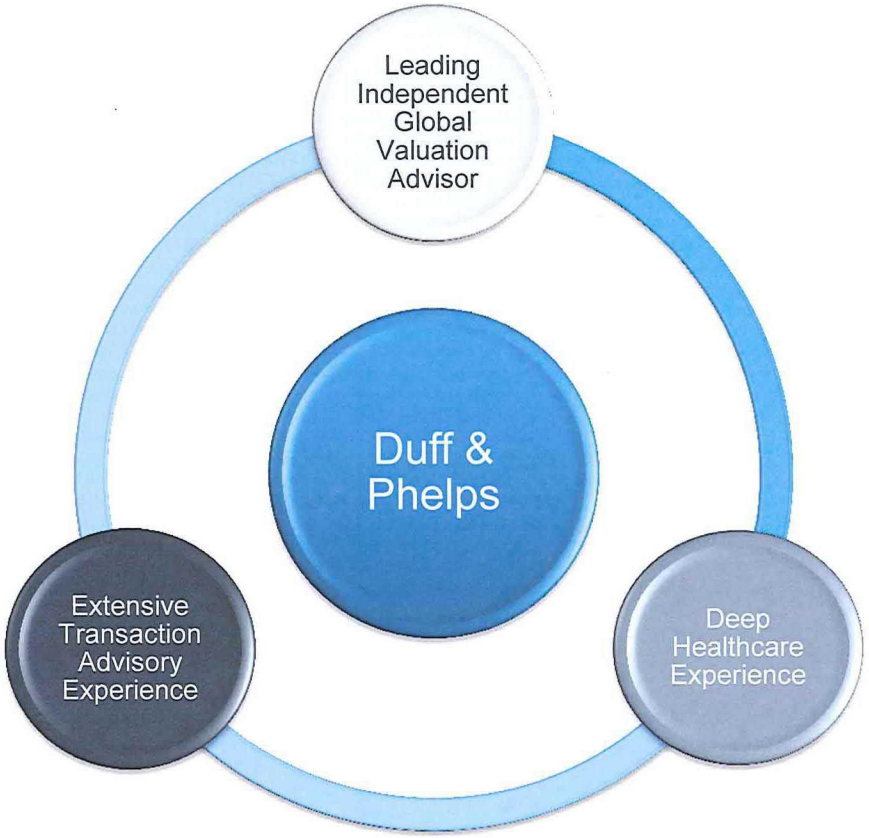
Summary of Qualifications

The blend of broad services and deep expertise that we offer make us uniquely qualified to provide the valuation and fairness opinion services requested by the board.

- **Leading Independent Global Valuation Advisor**
  - We provide a broad array of financial advisory and investment banking services, and valuation is the cornerstone of all that we do.
- **Deep Healthcare Industry Experience**
  - We have advised some of the most prominent healthcare companies in the United States and the world regarding valuation and other financial advisory matters.
- **Extensive Transaction Advisory Experience**
  - Our valuation work is not just theoretical. Through our investment banking practice, we provide merger & acquisition advisory services and transaction opinions on a wide range of corporate transactions.



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Healthcare Practice Overview





Duff & Phelps distinguishes itself with the depth of experience of our Healthcare Industry Group. Because we place so much importance on the industry expertise of our service team leaders, we bring a wealth of experience to each healthcare engagement. We believe that our healthcare clients are best served by those who have experience with the industry specific issues that are often unique to this sector.

Our experience in the healthcare is substantial:

- Our firm has performed numerous valuations in connection with various aspects of mergers & acquisitions, divestitures, partnerships, corporate restructuring, capital raising, and related-party transactions
- Our firm has substantial experience with the valuation of healthcare service providers, healthcare facilities, managed care plans, and companies engaged in medical technology, pharmaceuticals and biotechnology
- Our team will provide an educated analysis and meaningful conclusions formulated from our understanding of each client's issues and valuation drivers, as well as the best practices and trends that shape the future development of each company

Representative Healthcare Clients

HEALTHSOUTH. ManorCare RUSH UNIVERSITY MEDICAL CENTER Children's Memorial Hospital

Catholic Healthcare West MERITER USC UNIVERSITY OF SOUTHERN CALIFORNIA TORRANCE MEMORIAL MEDICAL CENTER UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

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Representative Healthcare Clients



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Selected Healthcare Experience

Fairness Opinion

Clear One Health Plans, Inc. has merged with PacificSource Health Plans, Inc.

ClearOne Health Plans

Financial advisor to the board of directors of Clear One Health Plans, Inc.

Debt Opinion

Tallahassee Memorial HealthCare, Inc. has entered into a tax-exempt financing with related parties

Tallahassee Memorial HealthCare

Financial advisor to the board of directors of Tallahassee Memorial HealthCare, Inc. and its tax and bond counsel.

Fairness Opinion

University of Southern California has acquired USC University Hospital and Norris Cancer Center from Tenet Healthcare Corp.

USC University of Southern California

Financial advisor to the board of trustees of the University of Southern California.

Debt Opinion

Yuma Regional Medical Center has entered into a tax-exempt financing with related parties

Yuma Regional Medical Center
Caring for the growing needs of our communities

Financial advisor to the board of directors of Yuma Regional Medical Center and its tax and bond counsel.

Fairness Opinion

Symbion Healthcare has acquired equity interests in certain entities operating under the Specialty Surgical Center name.

Specialty Surgical Center

Financial advisor to the board of directors of the target entities.

Debt Opinion

Sisters of St. Francis Health Services, Inc. has entered into a tax-exempt financing with related parties.

St. Elizabeth Regional Health
Sisters of St. Francis Health Services

Financial advisor to the board of directors of Sisters of St. Francis Health Services, Inc. and its tax and bond counsel

M&A Sell-Side Advisor

HealthNet, Inc. has sold its wholly owned subsidiaries, collectively known as VitalCare, to RehabCare Group.

Health Net

Financial advisor to HealthNet, Inc.

Solvency Opinion

Myriad Genetics, Inc. has completed the spin-off of Myriad Pharmaceuticals, Inc.

MYRIAD

Financial advisor to the board of directors of Myriad Genetics, Inc.

Selected Healthcare Experience

Sell-Side Advisor and Fairness Opinion

Clear One Health Plans, Inc. has merged with PacificSource Health Plans, Inc.

ClearOne Health Plans

Financial advisor to Clear One Health Plans, Inc. and its the board of directors.

Sell-Side Advisor

Care Ambulance Service, Inc. was acquired by Falck A/S.

CARE AMBULANCE SERVICE

Financial advisor to Care Ambulance Service, Inc.

Fairness Opinion

University of Southern California has acquired USC University Hospital and Norris Cancer Center from Tenet Healthcare Corp.

USC UNIVERSITY OF SOUTHERN CALIFORNIA

Financial advisor to the board of trustees of the University of Southern California.

Buy-Side Advisor

Meriter Health System, Inc. has acquired a controlling interest in Physicians Plus Insurance Corporation.

MERITER

Financial advisor to Meriter Health System, Inc.

Fairness Opinion

Children's Memorial Medical Center sold its interest in Focused Health Solutions, Inc. to Linden.

Children's Memorial Hospital

Financial advisor to the special committee of the board of directors of Children's Memorial Medical Center.

Solvency Opinion

United Surgical Partners International, a portfolio company of Welsh Carson, has completed a dividend recapitalization transaction in conjunction with the spin-off of its U.K. subsidiary to existing shareholders.

United Surgical Partners INTERNATIONAL

Financial advisor to the board of directors of United Surgical Partners International.

Buy-Side Advisor

Clear Choice Health Plans, Inc. has acquired Trusteed Plan Service Corporation.

CLEAR CHOICE HEALTH PLANS

Financial advisor to Clear Choice Health Plans, Inc.

Fairness Opinion

KKR Private Equity Investors, L.P. has sold a portion of its co-investment in HCA, Inc. to an affiliate of Kohlberg Kravis Roberts & Co.

HCA Hospital Corporation of America

Financial advisor to the independent directors of the general partner of KKR Private Equity Investors, L.P.

Selected Healthcare Experience

Private Financing

First Choice ER, LLC was financed by Sterling Partners.

FIRST CHOICE EMERGENCY ROOM

Financial advisor to First Choice, LLC

Solvency Opinion

Allscripts has completed a recapitalization transaction.

Allscripts™

Financial advisor to the board of directors of Allscripts.

Buy-Side Advisor

The Conjoin Group has acquired PHNS.

THE CONJOIN GROUP
TRANSFORM • FINANCE • GROW

Financial advisor to the Conjoin Group.

Solvency Opinion

Aveta, Inc. has completed a leveraged dividend recapitalization transaction.

Aveta

Financial advisor to the board of directors of Aveta, Inc.

Solvency Opinion

Universal American Corp. sold its Medicare Prescription Drug Business to CVS Caremark Corporation.

UNIVERSAL AMERICAN
A Healthy Collaboration℠

Financial advisor to the board of directors of Universal American Corp.

Fairness Opinion

Symbion Healthcare has acquired equity interests in certain entities operating under the Specialty Surgical Center name.

SPECIALTY SURGICAL CENTER

Financial advisor to the board of directors of the target entities.

Solvency Opinion

Cardinal Health, Inc. spun off CareFusion into a separate publicly traded company.

CardinalHealth

Financial advisor to the board of directors of Cardinal Health, Inc.

Sell-Side Advisor

Healthcare Laundry Systems has been acquired by Crothall Services Group.

HLS
Healthcare Laundry Systems

Financial advisor to Healthcare Laundry Systems.

Selected Healthcare Experience

Solvency Opinion

Center for Diagnostic Imaging has completed a recapitalization transaction.

CENTER FOR DIAGNOSTIC IMAGING

Financial advisor to the board of directors of Diagnostic Imaging Holdings, Inc. and Center for Diagnostic Imaging, Inc.

Fairness Opinion

Children's Mercy Hospital has completed the sale of its 100%-owned subsidiary, Children's Mercy's Family Health Partners, Inc. to Coventry Health Care, Inc.

Children's Mercy HOSPITALS & CLINICS

Financial advisor to the boards of directors of Children's Mercy Hospital and Children's Mercy's Family Health Partners, Inc.

Solvency Opinion

Trident USA Health Services, LLC has completed a recapitalization transaction.

TridentUSA℠ HEALTH SERVICES

Financial advisor to the board of directors of Trident USA Health Services, LLC.

Sell-Side Advisor

Pacific Ambulance, Inc. has been acquired by Rural/Metro Corporation, a portfolio company of Warburg Pincus LLC.

PACIFIC AMBULANCE

Financial advisor to Pacific Ambulance, Inc. and its shareholders.

Solvency Opinion

Myriad Genetics, Inc. has completed the spin-off of Myriad Pharmaceuticals, Inc.

MYRIAD®

Financial advisor to the board of directors of Myriad Genetics, Inc.

Sell-Side Advisor

Rush Behavioral Health Network has been acquired by Resurrection Health Care.

RUSH UNIVERSITY MEDICAL CENTER

Financial advisor to Rush University Medical Center.

Sell-Side Advisor

Bowers Companies, Inc. has been acquired by Rural/Metro Corporation, a portfolio company of Warburg Pincus LLC.

BOWERS AMBULANCE

Financial advisor to Bowers Companies, Inc. and its shareholders.

Solvency Opinion

Medical Card System has completed a recapitalization transaction.

MCS

Financial advisor to the board of directors of Medical Card System, Inc.

Additional Healthcare Industry Experience

Senior professionals were involved in the following valuation engagements prior to their employment with Duff & Phelps. These services were provided for a wide variety of purposes, including compliance with fraud and abuse regulations, tax and financial reporting, fulfillment of fiduciary duties, expert witness testimony and general transaction advisory.

Select Advisory Engagements

- Valuation of surgical center in connection with the sale of equity interests to affiliated physicians
- Valuation of IPA enrollment base in southern California in connection with a purchase by a local hospital
- Valuation of the technical component of a women's health screening business in connection with a purchase by the associated hospital
- Valuation of a large multi-specialty medical group in Arkansas in connection the purchase by the affiliated hospital
- Valuation of a large southern California physician practice management company for potential purchase by an associated hospital
- Valuation of medical group, management company, health insurance agency, and managed care portion of hospital business in connection with the potential formation of an integrated delivery system
- Valuation of an acute care hospital in Riverside County in connection with an application for loan insurance from Cal Mortgage
- Valuation of an acute care hospital in Dallas, Texas in connection with financing and buyer's application for not-for-profit status
- Valuation of an acute care hospital in northern California, and allocation of intangible value, in connection with potential eminent domain proceedings by local governmental body
- Valuation of an acute care hospital in Northern California in connection with a long-term lease negotiation
- Valuation of hospital-based pharmacy business in connection with an acquisition
- Valuation of a multiple location, multi-modality diagnostic imaging business in Riverside county for internal planning purposes
- Valuation of a Riverside county physician practice management company for donation to a not-for-profit entity

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Additional Healthcare Industry Experience

Select Advisory Engagements (continued)

- Valuation of a southern California physical therapy practice in connection with a minority shareholder buyout
- Valuation of a Nevada outpatient surgery center in connection with a purchase transaction
- Valuation of the technical component of a brain mapping and epilepsy treatment program in connection with mediation between the physician owners
- Valuation of a northern California home health agency in connection with a potential purchase of a minority interest
- Valuation of a multi-modality diagnostic imaging business in northern California in connection with a potential sale
- Valuation of a Medi-Cal HMO and related staff-model primary care practices for estate tax purposes
- Valuation of two southern California outpatient surgery centers in connection with potential buyout of minority partners
- Valuation of multiple home health agencies and related entities in connection with the formation of a new joint venture and the relative contributions thereto
- Valuation of two northern California ASC's in connection with the redemption of equity interests from certain affiliated physicians
- Valuation of a San Bernardino county physician practice management company in connection with the formation of an Employee Stock Ownership Plan
- Valuation of a southern California physician practice management company and related OB/GYN practice for litigation support purposes
- Valuation of a Los Angeles county IPA management company in connection with a potential buyout of the minority shareholder
- Valuation of 15 outpatient diagnostic imaging centers in connection with a tender offer to purchase outstanding limited partnership units

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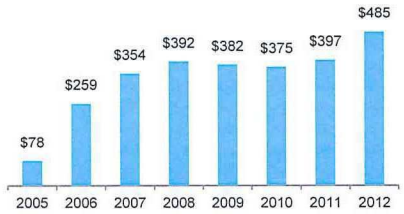
Section 2

Overview of Duff & Phelps

Duff & Phelps Overview

Delivering Value Since 1932

- Duff & Phelps Corporation is a leading provider of **investment banking** and independent **financial advisory services**, supporting client needs principally in the areas of M&A transactions, valuation, fairness opinions, financial restructurings and disputes
- We perform approximately 6,600 engagements annually for over 2,800 clients, including over one-third of the S&P 500
- We have advised clients for more than 80 years and have a proven track record in delivering value to clients



Annual Revenue (in millions of USD)

Leading Financial Advisory Firm

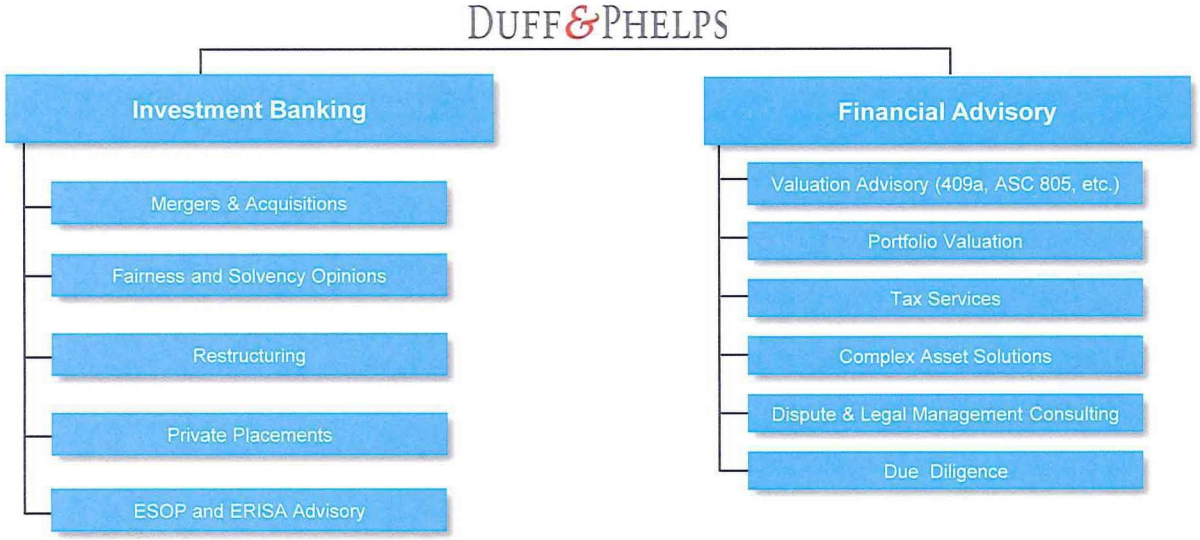
1,400+ Employees

Serving clients globally through

29 Offices

In North America, Europe and Asia

Diversified Advisory Capabilities



1932-1994

Duff & Phelps is founded and evolves into a diversified financial services firm providing investment banking and investment management services to companies across industries.

1994

The credit ratings business of Duff & Phelps is spun-off as a separate public company.

2005

Duff & Phelps acquires the Corporate Value Consulting ("CVC") business of Standard & Poor's. The constituent parts of CVC had been formed in the 1970s as part of PwC's valuation practice.

2007

Duff & Phelps lists on the New York Stock Exchange.

DUF LISTED NYSE

2009

Engaged by the U.S. Trustee for the Southern District of New York as the financial advisor to the examiner in the Lehman Brothers bankruptcy case.

Engaged by the Congressional Oversight Panel on the Troubled Asset Relief Program ("TARP") to analyze the government's investments in TARP.

2010

Established platform in Canada with acquisition of Cole & Partners, a Toronto-based independent financial advisory firm.

2011

Expanded Investment Banking platform with the acquisitions of MCR and RSM Richter's Financial Restructuring Practice in Toronto, Pagemill Partners, a technology-focused investment banking and valuation services firm and Growth Capital Partners, a Houston-based leading energy-focused middle-market merchant bank.

2013

Taken private by a consortium of leading financial sponsors, led by The Carlyle Group.

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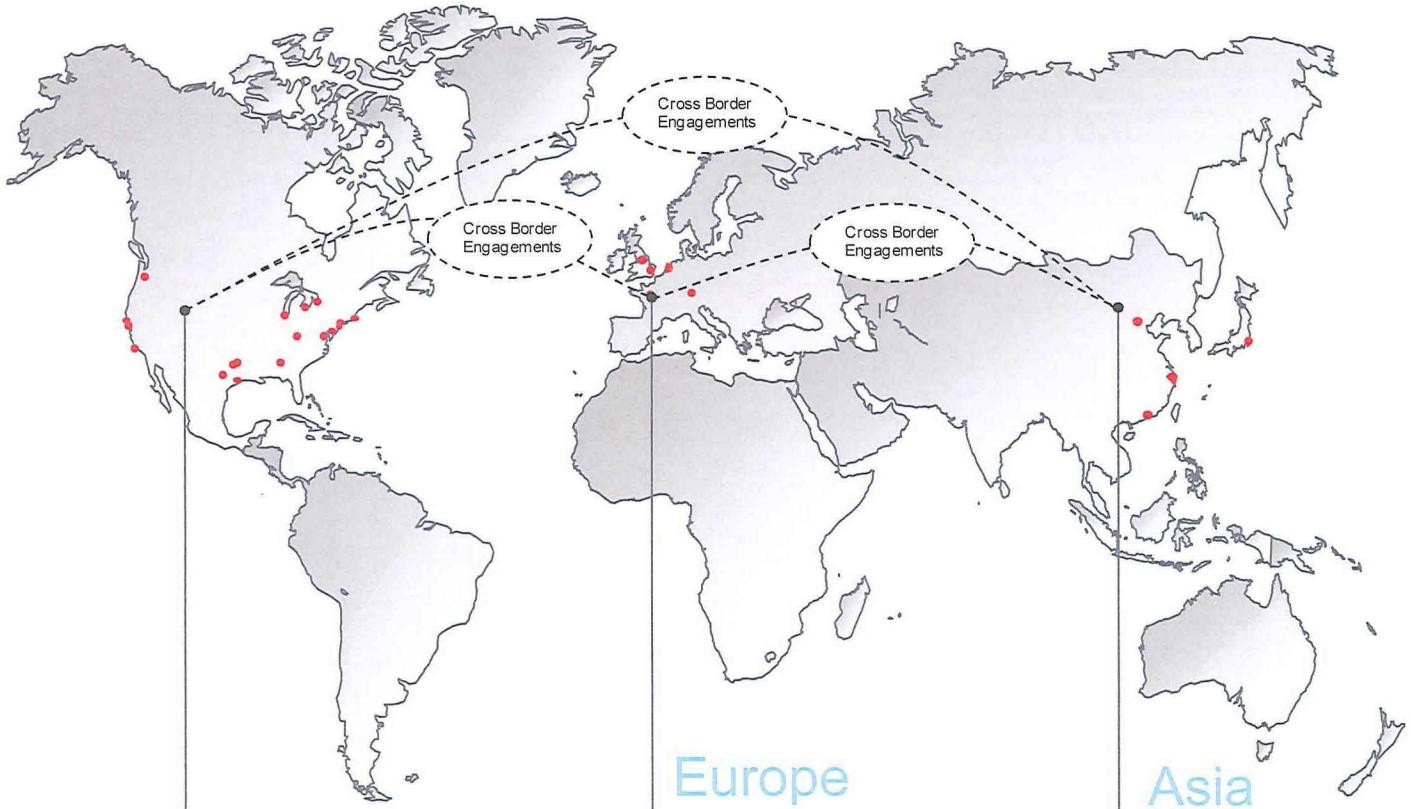
Strong Global Presence and Expertise

- Cross border transaction teams work seamlessly, combining specific industry and technical expertise
- Senior staffing commitment and involvement throughout the transaction process



North America

Atlanta, Austin, Boston, Chicago, Dallas (2), Denver, Detroit, Houston (2), Los Angeles, Morristown, New York, Philadelphia, San Francisco, Seattle, Silicon Valley, Toronto, Washington D.C.

Europe

London (2), Birmingham, Manchester, Amsterdam, Munich, Paris

Asia

Beijing, Hong Kong, Shanghai, Tokyo

One Corporation. **One** Team.

Sell Side Advisor

Southern Heat Exchanger Corp., a portfolio company of Harbour Group, has been acquired by NDA

Served as sell side advisor providing M&A advisory services to Southern Heat Exchanger Corp.

Sell Side Advisor

Channel Technologies, Inc. has sold its wholly-owned subsidiary Harris Acoustic Products to Ultra Electronics

Served as sell side advisor providing M&A advisory services to Channel Technologies, Inc.

Sell Side Advisor

Hydril Co. (NasdaqNM: HYDL) has been acquired by Tenaris SA (NYSE: TS)

A current Duff & Phelps professional served as sell side advisor to Hydril Co. (NasdaqNM: HYDL) with another firm

Sell Side Advisor

SEMCO Incorporated has been acquired by Flakt Woods Group, a portfolio company of Sagard Private Equity Partners, et al.

Served as exclusive financial advisor providing M&A advisory services to SEMCO Incorporated

Fairness Opinion

Master Tek International, Inc., a wholly owned subsidiary of SouthWest Water Co., has been acquired by Minol USA

Served as financial advisor providing a fairness opinion to the Board of Directors of SouthWest Water Co.

Sell Side Advisor

Talley Defense Systems, Inc., a 100% ESOP-owned company, has been acquired by Nammo AS

Served as exclusive financial advisor providing M&A advisory services to Talley Defense Systems, Inc.

Sell Side Advisor

Command Tooling Systems, LLC, a portfolio company of Norwest Equity Partners, has been acquired by EWS Tool Technologies

Served as sell side advisor providing M&A advisory services to Command Tooling Systems, LLC

Sell Side Advisor

H.C. Duke and Sons, Inc., d/b/a Electro Freeze, has been acquired by Ali Group Spa

Served as sell side advisor providing M&A advisory services to H.C. Duke and Sons, Inc.

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2012 Accomplishments

Ranked #1 investment bank by The Deal Pipeline – number of global bankruptcy cases from Q4 2011 through Q4 2012

Named **"UK Corporate Restructuring Advisor of the Year"** (2012 ACQ Financial Magazine Global Awards)

Ranked #1 Thomson Financial Securities Data – number of global fairness opinions in 2012

Ranked #3 Thomson Financial Securities Data – number of U.S. middle-market M&A transactions in 2012 (deals < $250M)

Named **"Services and Valuation Firm of the Year"** (2012 ACG New York Champion's Awards)

Named **"Mid Markets Restructuring Financial Advisor of the Year"** (2012 Turnaround Atlas Awards)

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Board Advisory and Transaction Opinions

- Duff & Phelps serves as an independent advisor to boards of directors, special committees and other fiduciaries and is a leading global provider of fairness, solvency and debt opinions in corporate transactions.

Key Services

- Fairness Opinions and Special Committee Advisory
- Solvency Opinions
- Commercially Reasonable Debt Opinions

Differentiators

- **Core Practice**: Ranked # 1 for fairness opinions in 2012 and the leading financial advisor for solvency opinions (over 311 solvency opinions and $1.3 trillion in deal value since 2005)
- **Independence**: Vast majority of our opinions involve transactions in which Duff & Phelps is not the investment banker
- **Analytical Rigor**: Comfortable providing opinions in transactions involving minority interests, debt securities and those transactions absent a market-clearing mechanism

2012 Global Fairness Opinion Rankings

Fairness Opinion Provider	No. of Deals	Rank
Duff & Phelps	**57**	**1**
JP Morgan	48	2
Stout Risius Ross Inc.	41	3
Houlihan Lokey	36	4
UBS	29	5
Morgan Stanley	28	6
Barclays	27	7
Deutsche Bank AG	27	7

Source: Thomson Financial Securities Data

Selected Transactions

Solvency Opinion & Fairness Opinion
United Rentals, Inc. has acquired RSC Holdings Inc.
United Rentals
Financial advisor to the board of directors of the Company

Solvency Opinion
Marriott International, Inc. has completed the spin-off of Marriott Vacations Worldwide Corp.
Marriott
Financial advisor to the board of directors of the Company

Fairness Opinion
On2 Technologies , Inc. has been acquired by Google Inc.
on2 technologies
Financial advisor to the board of directors of the Company

Fairness Opinion
CommScope, Inc. has acquired Andrew Corporation
CommScope
Financial advisor to the board of directors of the Company

Solvency Opinion
Clear Channel Outdoor Holdings, Inc., has completed a leveraged dividend recapitalization
Clear Channel Outdoor
Financial advisor to the board of directors of the Company

Solvency Opinion
T-Mobile USA, Inc., an indirect subsidiary of Deutsche Telekom AG, has issued cross-border debt to a related party as part of a leveraged recapitalization transaction
T-Mobile
Financial advisor to the board of directors of the Company

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Section 3

Professional Credentials

Christopher L. Janssen

Managing Director, Head of Transaction Opinions



Duff & Phelps Securities, LLC
311 S. Wacker Drive
Suite 4200
Chicago, IL 60606
+1 312 697 4643
Chris.Janssen@duffandphelps.com

Chris Janssen is a managing director in the Chicago office and head of the global Transaction Opinions group within the Investment Banking segment. He is also a member of the firm's Fairness and Solvency Opinion Senior Review Committee. Chris specializes in board and special committee advisory, fairness opinions, and solvency opinions. He has advised public and private companies and their boards of directors on numerous corporate transactions, including mergers and acquisitions, leveraged buy-outs, going-private transactions, spinoffs, split-ups and recapitalizations. Chris' experience includes:

- Advising the boards of directors of portfolio companies of ABRY Partners, Stone Point Capital, Hellman & Friedman, JLL Partners, Bain Capital, and The Blackstone Group on leveraged dividend transactions;
- Advising the boards of directors of Rockwood Holdings, Choice Hotels International, Delphi Automotive, Unisys, and Realogy on dividend and stock repurchase transactions;
- Advising the special committee of the board of directors of Andatee China Marine Fuel Services Company, National Investment Managers, and Eagle Point Software on going-private transactions;
- Advising the boards of directors of CommScope, Boulder Specialty Brands, and Patriot Coal on acquisitions; and
- Advising the boards of directors of Murphy Oil Corporation, Sears Holdings, Cardinal Health, American Standard, Bentley Pharmaceuticals, Cendant, and Tyco on spin-off transactions.

Chris has also been a guest lecturer on business valuations at the J.L. Kellogg Graduate School of Management. Prior to joining Duff & Phelps, he was a commercial lender with The Northern Trust Company in Chicago.

Chris received his M.B.A. in finance and marketing and *Beta Gamma Sigma* from Northwestern University's J.L. Kellogg Graduate School of Management and his B.A. in economics with highest distinction and *Phi Beta Kappa* from Northwestern University. He is also a Financial Industry Regulatory Authority registered representative and holds the Series 7 and 63 licenses. Chris is a member of the American Bar Association, the National Association of Corporate Directors and the Business Valuation Association of Chicago. He has been a host committee chair of the Greater Chicago Food Depository's Bag Hunger event.

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Todd Kaltman

Managing Director, Transaction Opinions



Duff & Phelps Securities, LLC
Los Angeles
+1 424 249 1693
todd.kaltman@duffandphelps.com

Todd Kaltman is a managing director in Duff & Phelps' Investment Banking unit, with a specialization in transaction opinions, which includes fairness and solvency opinions as well as valuations in the context of a corporate transaction. Todd is also a member of the firm's Senior Review Committee, which approves all fairness and solvency opinions issued by Duff & Phelps. He has been with Duff & Phelps for more than 12 years and has more than 20 years of experience providing corporate and securities valuation and financial advisory services.

Over the course of his career, Todd has provided financial opinions and advice to public and private companies in relation to mergers and acquisitions, recapitalization transactions, spin-offs, debt and equity securities issuance, joint venture formation and employee stock ownership plans. Todd has also provided valuations related to tax and financial reporting, shareholder buy/sell agreements, and marital and partnership dissolution.

He has experience across a wide range of industries, including financial services, food and agribusiness, manufacturing, professional services, technology and communications. In addition to this broader experience, Todd has substantial expertise in the healthcare services segment. Prior work has touched on nearly every aspect of this sector, including medical groups and IPAs, imaging and surgery centers, managed care plans, acute care and long-term care hospitals, skilled nursing and assisted living centers, and large integrated health systems.

Some of Todd's noteworthy engagements include: serving as investment banker to Health Net, Inc. in the sale of its VitalCare business to Rehabcare Group, Inc.; providing a fairness opinion to the board of trustees of the University of Southern California in connection with its acquisition of two hospital facilities from Tenet Healthcare; providing a fairness opinion to the board of directors of ClearOne Health Plans in connection with its merger with PacificSource Health Plans, Inc.; and serving as financial advisor to Sisters of St. Francis Health Services, Inc. in connection with an offering of tax-exempt debt securities to its affiliated physicians.

Todd received his B.S. in business administration, magna cum laude, from California State University, Northridge. He is a chartered financial analyst (CFA) charterholder and he holds the Financial Industry Regulatory Authority Series 7 and 63 licenses. He is also a member of the American Society of Appraisers, the CFA Institute, the CFA Society of Los Angeles, the National Association of Corporate Directors and the Association for Corporate Growth.

0594

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Todd A. Kaltman

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Duff & Phelps, LLC
Title: Managing Director

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO x YES. If YES, please provide details. My employer, Duff & Phelps, LLC received total professional fees of $155,000 plus expense reimbursement for providing a fairness opinion to the ECHN board of trustees

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

todd.kaltman@duffandphelps.com Digitally signed by: todd.kaltman@duffandphelps.com DN: CN = todd.kaltman@duffandphelps.com Date: 2014.09.26 08:45:04 -07'00'

Signature

9/26/14

Date

Todd A. Kaltman

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit limited liability company to be named prior to or at the time of the closing that is directly or indirectly owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") ("The Transaction").

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Nicolas Tarditti

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

x Expert or Consultant with:
Company Name: Duff & Phelps, LLC
Title: Director

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **October 10, 2014** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 1, 2011, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____NO X YES. If YES, please provide details. My employer, Duf & Phelps, LLC received total professional fees of

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 1, 2011, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 1, 2011, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 1, 2011, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

nick.tarditti@duffandphelps.com Digitally signed by: nick.tarditti@duffandphelps.com DN: CN = nick.tarditti@duffandphelps.com Date: 2014.10.07 10:18:44 -07'00'

Signature

10/7/2014

Date

Nicolas Tarditti

Printed Name

EXHIBIT 12 – DUFF & PHELPS' SCOPE OF ENGAGEMENT

DUFF & PHELPS

ORIGINAL

2013-886

Confidential

October 31, 2013

Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Ladies and Gentlemen:

This letter sets forth the terms of an agreement between Duff & Phelps, LLC ("Duff & Phelps") and Eastern Connecticut Health Network, Inc. and its wholly owned subsidiaries (collectively, the "Company") under which Duff & Phelps will serve as an independent financial advisor to the Company and its respective boards of trustees (collectively, the "Board of Trustees") (solely in their capacity as members of the Board of Trustees) (the Company and Board of Trustees collectively, the "Client") to provide an opinion (the "Fairness Opinion" as defined below) in connection with a proposed transaction (the "Proposed Transaction" as described below). Please review this letter agreement, including the attached Terms of Retention (collectively, the "Agreement"), as it will govern the engagement of Duff & Phelps (the "Engagement").

Description of the Proposed Transaction. It is Duff & Phelps' understanding that the Proposed Transaction involves the sale of substantially all of the assets of the Company and substantially all of the assets of the Company's subsidiaries to a third-party buyer for cash consideration and certain post-closing covenants.

Fairness Opinion. Duff & Phelps will opine as to the fairness, from a financial point of view, to the Company of the consideration to be received by the Company in the Proposed Transaction. Duff & Phelps hereby acknowledges and agrees that it is an independent third party with respect to the Proposed Transaction, and is an expert in providing opinions like the Fairness Opinion.

Nature and Scope of Engagement. The scope of this Engagement will include such inquiries, analyses, and other procedures as Duff & Phelps deems necessary to enable Duff & Phelps to render the Fairness Opinion, which Fairness Opinion shall take into account the criteria set forth in Connecticut General Statute §19a-486c(a), including but not limited to an analysis of the fair market value to be paid in connection with the Proposed Transaction. The Company shall make available to Duff & Phelps all documents and information concerning the Company's business and operations which Duff & Phelps reasonably requests, including, without limitation: current and historical financial information; financial projections or forecasts prepared by management; third-party appraisals or valuations previously performed, if any; and any other relevant information relating to the Company or the Proposed Transaction prepared by the Company or any of its other advisors. The Company will provide documentation relating to the Proposed Transaction as

Duff & Phelps, LLC
311 South Wacker Drive
Suite 4200
Chicago, IL 60606

T +1 312 697 4600
F +1 312 697 0112

www.duffandphelps.com

it becomes available. The Company will also provide Duff & Phelps with reasonable access to the Company's officers, directors, and legal, financial and accounting advisors as appropriate. In addition to reviewing documents and information provided by the Company, Duff & Phelps will also review industry and selected public company financial data it deems relevant, to the extent available, obtained from public and other available sources. Duff & Phelps will use generally accepted valuation and analytical techniques as the basis for its analysis and Fairness Opinion.

The scope of Duff & Phelps' analysis and Fairness Opinion will exclude any opinion as to the fairness of compensation arrangements arising from the Proposed Transaction which benefit any officer, director, or employee of the Company, or any class of such persons.

Prior to the issuance of the Fairness Opinion, Duff & Phelps will confirm certain facts and representations with the Company's management. Duff & Phelps may do this by providing the Company's management with drafts of the Fairness Opinion or presentation materials under the condition that in no circumstances are such drafts to be copied or given to other persons. Duff & Phelps may also require a letter from management confirming representations management has made and upon which Duff & Phelps has relied.

Upon concluding Duff & Phelps' analysis, and after the review of the findings, analysis, and conclusions by Duff & Phelps' Opinion Review Committee, Duff & Phelps would be available to make a presentation to the Client summarizing Duff & Phelps' analysis and conclusions at no additional cost other than reasonable out-of-pocket expenses. Assuming timely availability of management and receipt of the information requested, Duff & Phelps will provide the Fairness Opinion by November 19, 2013. The Fairness Opinion will be set out in a written opinion letter, which will be in a form and substance Duff & Phelps deems appropriate and will set forth the scope of its assignment, the principal materials reviewed and assumptions and qualifications upon which it has relied.

The Company will use its best efforts to facilitate a presentation by Duff & Phelps of its findings to the Client at a mutually convenient time and venue prior to final approval of the Proposed Transaction by the Client. The Company acknowledges that it is contracting with Duff & Phelps on an arm's length basis to provide the services described herein, and that it is not the intent of the parties to create a fiduciary relationship.

Fees. Duff & Phelps' professional fees for the Engagement will be $125,000, with a nonrefundable retainer of $45,000 payable upon execution of this Agreement, $40,000 payable on November 11, 2013, and $40,000 upon Duff & Phelps informing the Company that it is prepared to deliver the Fairness Opinion. No portion of these fees is refundable or contingent upon the consummation of a transaction or the conclusion reached in the Fairness Opinion. Furthermore, the Company agrees to pay additional fees at Duff & Phelps' standard hourly rates for any time incurred should Duff & Phelps be called upon to support its findings subsequent to the delivery of the Fairness Opinion (e.g., discuss its findings and analysis with a regulatory agency or deposition preparation and testimony as a fact witness) and/or to assist in the preparation or review of relevant sections of documents associated with the Proposed

Transaction. In addition to professional fees, the Company agrees to promptly reimburse Duff & Phelps, from time to time upon request, for its reasonable out-of-pocket expenses (including travel, meals, lodging, telephone, document reproduction, telecopying, computer charges, and database access fees), and for reasonable fees and expenses of outside counsel retained by Duff & Phelps, incurred in connection with the Engagement. In the event that: (1) the terms of the Engagement are modified after substantial completion of the analysis by Duff & Phelps in preparation of its Fairness Opinion and such modification requires substantial additional analysis or other services by Duff & Phelps, or (2) the Fairness Opinion is delivered subsequent to December 31, 2013, the Company agrees to negotiate in good faith the terms of additional compensation to Duff & Phelps.

Term. Either the Company or Duff & Phelps may terminate the Engagement at any time by written notice. After termination, Duff & Phelps will no longer be obligated to render any additional services, and the Company will only be liable for paying Duff & Phelps for its professional time in excess of the retainer and reimbursing Duff & Phelps for expenses incurred through the date of termination. The other terms of this Agreement will remain in effect, including the indemnification provisions set forth in the Terms of Retention.

Please indicate the Company's acceptance of, and agreement to, all of the terms and provisions of this Agreement by executing and returning it to Duff & Phelps along with the retainer.

Duff & Phelps, LLC

By: _____
Christopher L. Janssen
Managing Director

AGREED AND ACCEPTED BY:

Eastern Connecticut Health Network, Inc. for itself and on behalf of its wholly controlled subsidiaries

By: _____

Name:

Title:

Duff & Phelps, LLC
Terms of Retention

The following terms set out the agreements under which Duff & Phelps is being engaged by the Company on behalf of the Client. Capitalized terms used in these Terms of Retention but not defined herein have the meanings ascribed thereto in the letter agreement to which these Terms of Retention are attached.

Information. The Company agrees to promptly notify Duff & Phelps if the Company believes that any such information has become materially misleading. The Company further warrants and represents that any projections provided by it to Duff & Phelps will have been prepared in good faith and will be based upon assumptions which, in light of the circumstances under which they are made are reasonable. In rendering its services hereunder, Duff & Phelps assumes no responsibility for, and will not independently verify, the accuracy or completeness of any information provided by or on behalf of the Company, any other information provided or otherwise made available to Duff & Phelps regarding the Company or the Proposed Transaction, or any other information, data, advice, opinions or representations, whether obtained from public or private sources. Duff & Phelps' Fairness Opinion will state that it has not independently verified the accuracy or completeness of any such information.

Certain Limitations. Duff & Phelps will not evaluate the Company's solvency or independently appraise or physically inspect any of the Company's specific assets or liabilities (contingent or otherwise). Duff & Phelps further will not independently investigate any legal matters involving the Company. The Fairness Opinion will not address any related transaction, will not address the market price or value of any of the Company's securities following the announcement or consummation of the Proposed Transaction, and will not constitute a recommendation as to how the Client or any stockholder should vote or act with respect to any matters relating to the Proposed Transaction or any related transactions. The Fairness Opinion will be based upon Duff & Phelps' assessment of general economic, financial, and market conditions as they exist and can be evaluated by Duff & Phelps as of the date of the Fairness Opinion. The Fairness Opinion is inherently subjective; reasonable professionals or individuals reviewing the same information could reach different conclusions. The ultimate decision must be made by the Client and will need to take into account factors unrelated to the specific financial analysis provided by Duff & Phelps. The Fairness Opinion will specifically set forth these and other reasonable limitations and will state that, to the extent that any of these assumptions or any of the facts on which the Fairness Opinion is based proves to be untrue in any material respect, the Fairness Opinion could not and should not be relied upon. Duff & Phelps will provide the services described herein but will not act as an agent or broker to any person. Duff & Phelps will not solicit the purchase or sale of securities.

Coordination; Legal Matters. For Duff & Phelps to be effective, it will need the cooperation of the Company and its other advisors. The Company acknowledges that it will need to retain counsel for review of legal matters. Duff & Phelps may rely upon the fact that the Company has been advised by counsel as to all legal matters and may further rely on any advice given the

Company by such counsel. Duff & Phelps will not make, and assumes no responsibility to make, any representation, or render any opinion, as to any legal matter.

Confidentiality. Duff & Phelps will use any non-public or proprietary information provided by the Company ("Confidential Information") solely in the course of this Engagement and in a manner which Duff & Phelps believes in good faith is consistent with the Company's interests or is required by law. To allow Duff & Phelps to comply with this obligation, all Confidential Information whose sensitivity and confidentiality is not obvious must be marked "confidential."

Use of Advice. It is understood that the advice rendered by Duff & Phelps is solely for the information of the Client (including its corporators) in connection with its evaluation of the Proposed Transaction and may not be used for any other purpose without Duff & Phelps' prior written consent. Notwithstanding the prior sentence, Duff & Phelps' Fairness Opinion may be included in its entirety by Client in response to any request by or filing with a regulatory agency or court made by the Client in connection with the Proposed Transaction. The Client may also summarize or otherwise reference the existence of the Fairness Opinion in response to any press or other inquiry provided that any such summary or reference language shall be subject to the prior approval of Duff & Phelps. Except as set forth above, the Client agrees to obtain Duff & Phelps' written consent (not to be unreasonably withheld) before disclosing any of Duff & Phelps' advice or analysis to anyone, or otherwise making reference to its role, whether orally or in writing.

Potential Conflicts. Duff & Phelps has undertaken a limited review of its records to determine Duff & Phelps' professional relationship with the Client, and other parties of interest, and has identified no current relationships that would preclude it from accepting this Engagement. However, Duff & Phelps may represent (in unrelated matters), parties interested in the Company or the Proposed Transaction, or persons who are the Company's competitors or creditors, or whose interests otherwise conflict with those of the Company. Duff & Phelps will not have any obligation to disclose any unrelated representation or any information it learns in the course of any unrelated representation to the Company, or to use that information in connection with the Engagement.

Relationships and Compensation. It is understood and agreed that any Fairness Opinion rendered by Duff & Phelps with respect to the Proposed Transaction may disclose: (1) Duff & Phelps' role with respect to the Proposed Transaction, (2) the compensation therefor and any other payment or compensation that Duff & Phelps will receive which is contingent upon the successful completion of the Proposed Transaction, for rendering the Fairness Opinion, and/or for serving as an advisor, and (3) any material relationship that existed during the two years preceding the date of such Fairness Opinion or that, as of such date, is mutually understood to be contemplated and any compensation received or to be received as a result of the relationship between Duff & Phelps, the Company, and/or any party involved in the Proposed Transaction. In order to facilitate such disclosures, the Company will (and will exercise commercially reasonable efforts to cause any other parties to the Proposed Transaction to) cooperate with Duff & Phelps to identify and describe any material relationships between the Company or any other transaction

party and Duff & Phelps that existed during the two years preceding the date of the Fairness Opinion or that is mutually understood to be contemplated as of the date of the Fairness Opinion, and any compensation received or to be received by Duff & Phelps as a result of such relationship between Duff & Phelps and the Company or any other transaction party.

Corporate Obligation. The obligations of Duff & Phelps are solely corporate obligations. None of its directors, officers, employees, agents, stockholders, or controlling persons will individually be subject to any liability to the Company or anyone else, and the Company will not assert any such claim.

Disputes. Client and Duff & Phelps do not anticipate any disputes between them, but it is always prudent to provide a rational process to resolve any that may occur. Client and Duff & Phelps agree that any legal action or proceeding with respect to this Agreement may be brought in the courts of the State of New York or of any United States District Court located in the State of New York, and each consents to the non-exclusive jurisdiction of those courts. Client and Duff & Phelps hereto also irrevocably waive any objection, including any objection to the laying of venue or based on the grounds of forum non conveniens, which it may now or hereafter have to the bringing of any action or proceeding in such jurisdiction in respect of this Agreement. Client and Duff & Phelps waive personal service of any summons, complaint, or other process, which may be made by any other means permitted by the law of such state. Each of Duff & Phelps and the Client waives its constitutional right to a jury trial. Solely for purposes of enforcing the indemnification provisions herein, the Company hereby consents to personal jurisdiction, service of process, and venue in any court in which any Claim which is subject to the terms provided for herein is brought against Duff & Phelps or any other Indemnified Person. Client and Duff & Phelps agree that any legal proceeding arising from or in connection with this Engagement (or any variation or addition thereto) must be commenced within one year from the date when such party becomes aware of or ought reasonably to have become aware of the facts which give rise to the alleged liability and in any event not later than two years after any alleged breach of contract or act of gross negligence or commission of any other tort.

Indemnification and Contribution. The Company agrees to promptly, upon demand, indemnify and hold harmless Duff & Phelps and its affiliates, and its and their respective directors, officers, attorneys and other agents, stockholders, employees, and controlling persons (each an "Indemnified Person"), from and against any losses, claims, damages, judgments, assessments, and liabilities (joint or several) to the Company or third parties, (collectively, "Losses"), and will reimburse each Indemnified Person for all costs (including, without limitation, expenses, fees and disbursements, and time charges related to giving testimony or furnishing documents in response to a subpoena or otherwise) and fees and expenses (including, without limitation, reasonable fees and disbursements of counsel and accountants and the costs of any investigation and preparation) as and when they are incurred (collectively, "Expenses"), resulting directly or indirectly from any threatened or pending investigation, lawsuit, action, claim, proceeding, or dispute, including securityholder actions (whether or not Duff & Phelps or any other Indemnified Person is a potential or actual named party or witness) (collectively, a "Claim"), which: (1) are related to or arise out of any untrue statement or alleged untrue statement of a material fact

contained in any oral or written information provided to Duff & Phelps or any other person by the Company or used by the Company in connection with the transaction contemplated by this Agreement or any omission or alleged omission by the Company to state therein a material fact necessary to make the statements therein, in light of the circumstances under which they were made, not misleading, or (2) are otherwise related to or arise out of Duff & Phelps' Engagement, role, activities, or the performance or non-performance of professional services on the Company's behalf. The Company will not be responsible, however, for any Losses or Expenses pursuant to clause (2) of the preceding sentence which are judicially determined to have resulted primarily from the fraud, willful misconduct or gross negligence of the Indemnified Person; but pending any such judicial determination, the indemnification and reimbursement obligations of the Company hereunder shall continue to apply. Upon any such determination any Losses or Expenses previously funded by the Company shall be refunded by such Indemnified Person. However, the Company will not be responsible for any Losses which: (1) result from any settlement not approved by the Company in its reasonable judgment, or (2) are determined by a final judgment of a court of competent jurisdiction to have resulted primarily and directly from the fraud, willful misconduct or gross negligence of an Indemnified Person. The Company also agrees that no Indemnified Person will be liable to the Company for or in connection with this Engagement, except for Losses incurred by the Company which are determined by a final judgment of a court of competent jurisdiction to have resulted primarily and directly from the fraud, willful misconduct or gross negligence of that Indemnified Person.

Duff & Phelps will notify the Company if it learns that any Claim has been instituted based, directly or indirectly, on the transactions which were the subject of Duff & Phelps' Engagement under the Agreement, although failure to do so will not relieve the Company from any obligation or liability it has hereunder or otherwise, except to the extent such failure causes the Company to forfeit substantial rights and defenses. Should any Claim be formally instituted against Duff & Phelps or any other Indemnified Person based, directly or indirectly, on Duff & Phelps' Engagement under the Agreement, the Company will be entitled to participate therein with counsel chosen by it and, to the extent that it may wish or as requested by Duff & Phelps, to assume the defense of the Claim, with counsel reasonably satisfactory to Duff & Phelps, so long as the Company continues to pay all costs and expenses of the defense and preparation for such Claim. Even if the Company assumes the defense of a Claim, each Indemnified Person will have the right to participate in such Claim and to retain its own counsel. The Company will be required to pay all reasonable fees and expenses of such counsel as they are incurred only if: (1) such Indemnified Person has been advised by such counsel that there may be legal defenses available to it which are in conflict with or are materially different from or additional to defenses available to the Company (in which case the Company shall not have the right to assume the defense of the Claim on behalf of such Indemnified Person), (2) the Company shall not have assumed the defense of the Claim and employed counsel reasonably satisfactory to such Indemnified Person in a timely manner, or (3) the Company shall have authorized the employment of such counsel in connection with the defense of the Claim.

If any indemnification sought by an Indemnified Person pursuant to the terms hereof is held by a court of competent jurisdiction to be unavailable for any reason or insufficient to hold such

Indemnified Person harmless (other than as a result of the fraud, willful misconduct or gross negligence of any such Indemnified Person), then the Company and Duff & Phelps will contribute to the Losses and Expenses for which such indemnification is held unavailable or insufficient in such proportion as is appropriate to reflect the relative benefits of the Company and the Indemnified Person, or if such allocation is not permitted by applicable law, then in such proportion as is appropriate to reflect not only the relative benefits received by the Company and the Indemnified Person, but also the relative fault of the Company, its directors, officers, employees, affiliates, agents and advisors, on the one hand, and the Indemnified Person, on the other hand, as well as any other relevant equitable considerations, subject to the limitation that the contribution by Duff & Phelps and the other Indemnified Persons will not exceed the amount of fees actually received by Duff & Phelps pursuant to Duff & Phelps' Engagement. The Company agrees that for the purposes hereof the relative benefits received, or sought to be received, by the Company and its securityholders and creditors and ourselves shall be deemed to be in the same proportion as (i) the total value paid or proposed to be paid or received by the Company and its securityholders and creditors, as the case may be, pursuant to the Proposed Transaction (whether or not consummated) for which Duff & Phelps has been engaged to perform the services described in this Agreement bears to (ii) the fees paid or proposed to be paid to Duff & Phelps in connection with the Engagement. No person found liable for fraudulent misrepresentation shall be entitled to contribution from any person who is not also found liable for such fraudulent misrepresentation.

These indemnification and contribution provisions shall: (1) remain operative and in full force and effect regardless of any termination or completion of the Engagement; (2) inure to the benefit of the successors, assigns, heirs, or personal representative of any Indemnified Person; (3) be in addition to any other rights that any Indemnified Person may have at common law or otherwise; and (4) apply to activities prior to this date and after any amendment, modification, or future addition to the Agreement.

Settlement of Claims. The Company will not, without the prior written consent of Duff & Phelps (which consent shall not be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any pending or threatened Claim in respect of which indemnification or contribution could be sought hereunder (whether or not Duff & Phelps or any other Indemnified Person is a potential or actual named party to such Claim) unless such settlement, compromise, consent, or termination includes provisions holding harmless and unconditionally releasing Duff & Phelps and each other Indemnified Person hereunder from all liability related to or arising out of such Claim, including claims for contribution.

Miscellaneous. Notice given pursuant to any of the provisions of this Agreement shall be in writing and shall be mailed or delivered: (a) if to the Company, at its offices at 71 Haynes Street, Manchester, CT 06040; and (b) if to Duff & Phelps, at its offices at 55 East 52nd Street, 31st Floor, New York NY 10055, Attention: General Counsel with a copy to Christopher L. Janssen, 311 S. Wacker Drive, Suite 4200, Chicago, IL 60606.

This Agreement has been and is made solely for the benefit of the Client, Duff & Phelps and the Indemnified Persons and their respective successors and assigns. No other person shall acquire or have any right under or by virtue of this Agreement.

This Agreement: (1) contains all of the understandings between the parties hereto with respect to the subject matter hereof, and no party can rely upon or be bound by any understanding or statement, oral or otherwise, not specifically in this Agreement; (2) cannot be modified or changed except by a written instrument signed by each party hereto; (3) shall be governed by the law of the State of New York, without regard to any conflicts of law provisions; (4) may be executed in counterparts; and (5) shall inure to the benefit of, and shall be binding upon, the respective successors and assigns of the parties hereto and the Indemnified Persons. If any term, provision, covenant, or restriction contained in this Agreement is unenforceable, the remainder of this Agreement shall remain in full force and effect and shall not be affected, impaired, or invalidated in any way.

Duff & Phelps, LLC

By: _____
Christopher L. Janssen
Managing Director

AGREED AND ACCEPTED BY:

Eastern Connecticut Health Network, Inc. for itself and on behalf of its wholly controlled subsidiaries

By: _____

Name: Michael D. Veillette

Title: Sr. VP and CFO

EXHIBIT 13 – DUFF & PHELPS' FAIRNESS ANALYSIS

DUFF & PHELPS

ECHN℠
Eastern Connecticut Health Network

Eastern Connecticut Health Network, Inc.

Fairness Analysis

April 9, 2014

The information contained herein is of a confidential nature and is intended for the exclusive use of the persons or firm to whom it is furnished by us.
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Duff & Phelps Disclaimer

- The following pages contain material that is being provided by Duff & Phelps, LLC ("Duff & Phelps") to the board of trustees (the "Board of Trustees") of Eastern Connecticut Health Network, Inc. and its wholly owned subsidiaries (the "Company" or "ECHN") in connection with the Proposed Transaction (as defined herein).
- The accompanying material was compiled and prepared on a confidential basis for the use of the Board of Trustees and not with a view toward public disclosure and, except as expressly provided for in the engagement letter between Duff & Phelps and the Company dated October 31, 2013 (the "Engagement Letter"), may not be disclosed, summarized, reproduced, disseminated or quoted from or otherwise referred to, in whole or in part, without the prior written consent of Duff & Phelps.
- Without limiting the statement made in the prior bullet, because this material was prepared for use in the context of a presentation to the Board of Trustees, which is familiar with the business, assets, liabilities, prospects and affairs of the Company, neither the Company nor Duff & Phelps, nor any of their respective legal or financial advisors or accountants take any responsibility for the accuracy or completeness of any of the material if used by persons other than the Board of Trustees.
- These materials are not intended to represent an opinion but rather to serve as discussion materials for the Board of Trustees to review and as a summary of the basis upon which Duff & Phelps may render an opinion.
- The information utilized in preparing this presentation was obtained from the Company and public sources. Duff & Phelps relied without independent verification upon the accuracy, completeness, and fair presentation in all material respects of all information reviewed; and relied without independent verification on the accuracy of data and representations that Duff & Phelps obtained from public sources, private sources, and Company management ("Management").
- Duff & Phelps has relied on the Company's representation that any estimates and projections contained herein have been prepared in good faith by the Management of the Company. Such estimates and projections involve numerous and significant subjective assumptions and determinations, which may or may not prove to be correct. Projections necessarily involve risks and uncertainties. No representation or warranty, expressed or implied, is made as to the accuracy or completeness of such information, or the achievability of any such estimates or projections, and nothing contained herein is, or shall be relied upon as, a representation, whether as to the past, present, or the future. Duff & Phelps did not independently verify such information and expressly disclaims any and all liability relating to or resulting from the use of this material.
- Duff & Phelps did not independently appraise or physically inspect any of the Company's assets or liabilities (contingent or otherwise).
- No selected public company used in our analysis is directly comparable to the Company.
- These materials should not be construed as a valuation opinion, credit rating, solvency opinion, an analysis of the Company's credit worthiness, or as tax advice, or as accounting advice. Any opinion rendered by Duff & Phelps would be provided in a separate written opinion letter. Duff & Phelps has not made, and assumes no responsibility to make, any representations, or render any opinion, as to any legal or regulatory matters.
- Duff & Phelps is not addressing the merits of the underlying business decision to enter into the Proposed Transaction nor addressing any related transaction. Duff & Phelps makes no recommendation as to how the Board of Trustees or any other party should vote or act with respect to any matter relating to the Proposed Transaction or any related transactions.

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I. Introduction and Scope of Analysis

Introduction and Scope of Analysis

Background of Engagement

Engagement

- Duff & Phelps has been engaged by the Company to serve as an independent financial advisor to the Board of Trustees (solely in its capacity as such) to provide an opinion (the "Opinion" as defined below) in connection with a proposed transaction (the "Proposed Transaction" as described below).

- Specifically, Duff & Phelps has been asked to opine as to the fairness, from a financial point of view, to the Company of the consideration to be received by the Company in the Proposed Transaction.

Proposed Transaction

- It is Duff & Phelps' understanding that the Proposed Transaction involves the sale of substantially all of the assets of the Company and substantially all of the assets of the Company's subsidiaries to a third-party buyer for cash consideration in the amount of $105 million, subject to adjustment for certain assumed liabilities and other items as more fully described in the Asset Purchase Agreement (as defined herein).

- It is our further understanding that the buyer will make certain post-closing covenants with respect to the continued provision of medical services as well as a minimum level of future capital investment.

- For the purpose of our analysis, we have assumed that all joint venture investments held by ECHN (the "JV Investments") are sold as part of the Proposed Transaction. We have further assumed that in the event any JV Investments are sold in a separate transaction or transactions, any related purchase price reduction is not materially greater than the amount of consideration received by the Company in such separate sale.

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Introduction and Scope of Analysis

Scope of Analysis

In connection with this Opinion, Duff & Phelps has made such reviews, analyses and inquiries as it has deemed necessary and appropriate under the circumstances. Duff & Phelps also took into account its assessment of general economic, market and financial conditions, as well as its experience in securities and business valuation, in general, and with respect to similar transactions, in particular. Duff & Phelps' procedures, investigations, and financial analysis with respect to the preparation of its Opinion included, but were not limited to, the items summarized below:

- Reviewed the following documents:
  - The Company's consolidated audited financial statements for the fiscal years ("FY") ended September 30, 2010 through 2013 and the Company's unaudited interim financial statements for the five-month periods ended February 28, 2013 and 2014;
  - Various audited and unaudited financial statements related to the JV Investments;
  - Other internal documents relating to the history, current operations, and probable future outlook of the Company, including financial projections for FY 2014 through FY 2017, provided to us by Management (the "Management Projections"); and
  - Documents related to the Proposed Transaction, including the draft Asset Purchase Agreement, dated April 4, 2014 by and between Eastern Connecticut Health Network, Inc. and VHS Eastern Connecticut Health System, LLC (the "Asset Purchase Agreement");
- Discussed the information referred to above and the background and other elements of the Proposed Transaction with the Management;
- Performed certain valuation and comparative analyses using generally accepted valuation and analytical techniques including a discounted cash flow analysis, an analysis of selected public companies that Duff & Phelps deemed relevant, and an analysis of selected transactions that Duff & Phelps deemed relevant; and
- Conducted such other analyses and considered such other factors as Duff & Phelps deemed appropriate.

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II. Executive Summary

Executive Summary

Transaction Background

- According to management, ECHN determined during 2011 that a stand-alone strategy was no longer a viable option. This determination was based in part on:
  - Weak financial performance – low growth and low margin
  - Coupled with a high debt burden and growing pension liability
  - Leading to an inability to make necessary capital investment in equipment, facilities and technology
  - Leading to difficulties in attracting and retaining both patients and physicians
  - Resulting in further deteriorating financial performance and potential violation of bond covenants

- As a result, in 2012 the Company circulated a request for proposal to six parties with hospital operations in Connecticut, soliciting a range of transaction alternatives.

- In January 2013, the Company received four proposals that ranged from a management agreement, to a network affiliation, to an outright purchase.

- Based on its evaluation of the proposals received, ECHN came to an agreement with Vanguard Health Systems ("Vanguard") (subsequently acquired by Tenet Healthcare Corporation) and Yale New Haven Health System ("YNHHS") under which Vanguard and YNHHS would form a new for profit entity (the "Buyer") that would acquire substantially all of the assets and assume certain liabilities of ECHN.

- The initial agreement envisioned a purchase price of $135 million, but that amount was subsequently revised to $105 million after completion of financial due diligence by the Buyer.

- Additionally, as a part of the Proposed Transaction, the Buyer will agree to covenant as to:
  - The continuation, for a minimum of three years, of providing certain healthcare services that ECHN currently provides;
  - The continuation of ECHN's current policies of providing charity care, indigent care and other community services;
  - The maintenance and financial support for certain health professions teaching programs established by ECHN; and
  - The expenditure of not less than $75 million on capital projects within five years of closing.

Executive Summary

Valuation Conclusions

- The following table summarizes our valuation of ECHN relative to the Proposed Transaction.

Conclusion Summary

($ in thousands)

	Estimated Range of Values			Proposed Transaction
	Low	Mid	High	
Enterprise Value				
Discounted Cash Flow Analysis	$52,700	$56,200	$60,300	
Market Approach	55,700	61,300	66,900	
Estimated Enterprise Value (excluding JV Investments)	54,200	58,800	63,600	
Plus: Estimated Value of JV Investments	15,200	16,400	17,500	
Plus: Cash Transferred (1)	6,300	6,300	6,300	
Value of Assets Transferred / Gross Purchase Price	$75,700	$81,500	$87,400	$105,000
Assumed Liabilities:				
Unfunded Pension / Post-Retiree Health Plan Liability (2)	(44,197)	(44,197)	(44,197)	(44,197)
Captive Insurer / Workers' Compensation Liability (3)	(8,451)	(8,451)	(8,451)	(11,450)
Capital Lease Obligations (4)	(13,206)	(13,206)	(13,206)	(13,206)
Net Value of Assets Transferred / Net Purchase Price	$9,846	$15,646	$21,546	$36,147

Implied Enterprise Value Multiples (excluding JV Investments):

2013 Adjusted Revenue	$309,255	0.18x	0.19x	0.21x
2013 Adjusted EBITDAP	7,869	6.9x	7.5x	8.1x
Proj. 2014 Adjusted EBITDAP	11,142	4.9x	5.3x	5.7x
Proj. 2015 Adjusted EBITDAP	10,680	5.1x	5.5x	6.0x

(1) Based on a negotiated amount included in the Asset Purchase Agreement
(2) Based on audited financial statements as of September 30, 2013
(3) $8.45 million based on audited financial statements as of September 30, 2013; $17.75 million in the Proposed Transaction based on a negotiated amount included in the Asset Purchase Agreement
(4) Based on September 30, 2013 audited financial statements adjusted for certain additional capital lease obligations related to current projects
EBITDAP = Earnings before interest, taxes, depreciation, amortization and pension/post-retirement healthcare expense

III. Methodology

Valuation Analysis

Methodologies

Valuation of the Company

- Discounted Cash Flow Analysis
  - The Discounted Cash Flow ("DCF") analysis is based on the theory that the current vale of an investment is based on the expected receipt of future economic benefits. The DCF value includes the present value of interim cash flows plus the present value of the terminal value. The terminal value of the Company was estimated by applying the Gordon Growth Model to the debt free net cash flow generated by the Company in FY 2017.

- Selected Public Companies Analysis
  - Analyzed financial performance and trading multiples of selected public companies in the industry in which the Company operates.
  - Compared the Company's financial performance and other operating characteristics with those of the selected public companies.
  - Applied valuation multiples to the Company's financial performance to derive indications of total enterprise value.

- Selected M&A Transaction Analysis
  - Identified transactions involving the sale of a controlling interest in companies we deemed similar to the Company.
  - Analyzed the implied valuation multiples paid (Enterprise Value as a multiple of revenue, EBITDA and beds in service).

Valuation of the JV Investments

- Selected Public Company Analysis – JV Investments
  - Applied valuation multiples to the estimated after-tax net income of the JV Investments to derive indications of value.
  - Analyzed the implied distribution yield from the distributions of the JV Investments relative to the indications of value.

- Gordon Growth Approach
  - Applied the Gordon Growth Model to the after-tax pro form distributions of the JV Investments.

IV. Financial Performance

Financial Performance

ECHN Historical and Projected Financial Performance Summary – Unadjusted

Financial Performance Summary

($ in thousands)

FYE September 30:	Audited Financial Statements 2010	2011	2012	2013	YTD February 28, 2013 (Internal)	2014 (Internal)	LTM 2/28/14	Management Projections 2014	2015	2016	2017
Net Patient Revenue (1)	$251,337	$250,242	$265,758	$298,980	$125,413	$126,458	$300,024	$307,651	$316,898	$329,156	$340,478
Other Operating Revenue	17,827	19,641	28,839	28,988	13,119	14,651	30,520	21,908	21,121	20,336	20,431
Total Revenue	269,163	269,884	294,597	327,968	138,532	141,109	330,545	329,559	338,019	349,492	360,909
% Growth		*0.27%*	*9.16%*	*11.33%*	*NA*	*1.86%*	*NA*	*0.49%*	*2.57%*	*3.39%*	*3.27%*
Salaries and Wages	131,183	134,218	139,916	163,729	67,305	67,793	164,218	166,530	169,860	171,559	173,274
Fringe Benefits	32,963	35,697	40,920	47,592	19,655	19,138	47,075	45,486	47,262	48,371	49,204
Supplies and Other (2)	81,433	83,803	93,818	100,335	45,160	47,769	102,945	88,074	90,935	93,878	96,910
Physician Fees (2)	NA	NA	NA	NA	NA	NA	NA	12,524	12,900	13,287	13,685
Total Operating Expenses	245,579	253,718	274,654	311,657	132,119	134,700	314,238	312,613	320,957	327,095	333,074
EBITDA	23,584	16,166	19,943	16,311	6,413	6,409	16,307	16,945	17,062	22,397	27,835
% Margin	*8.8%*	*6.0%*	*6.8%*	*5.0%*	*4.6%*	*4.5%*	*4.9%*	*5.1%*	*5.0%*	*6.4%*	*7.7%*
Depreciation and Amortization	(12,556)	(11,899)	(11,812)	(12,291)	(5,816)	(5,368)	(11,842)	(12,300)	(12,300)	(12,300)	(12,300)
EBIT	11,028	4,267	8,131	4,020	597	1,041	4,464	4,645	4,762	10,097	15,535
Capital Expenditures	$7,394	$10,620	$7,498	$12,105	$8,017	$3,281	$7,369	$11,000	$11,000	$11,000	$11,000
as % of Total Adjusted Revenue	*2.6%*	*3.7%*	*2.5%*	*3.9%*	*2.5%*	*1.0%*	*2.2%*	*3.4%*	*3.4%*	*3.2%*	*3.1%*
Net Working Capital	$17,706	$19,307	$17,101	$16,221	$21,303	$25,007	*NA*	$24,579	$23,435	$25,040	$26,488
as % of Total Adjusted Revenue	*6.2%*	*6.8%*	*5.7%*	*5.2%*	*6.7%*	*7.6%*	*NA*	*7.7%*	*7.1%*	*7.4%*	*7.5%*
Salaries and Wages % of Net Patient Revenue	*52.2%*	*53.6%*	*52.6%*	*54.8%*	*53.7%*	*53.6%*	*54.7%*	*54.1%*	*53.6%*	*52.1%*	*50.9%*
Salaries, Wages and Benefits % of Net Patient Revenue	*65.3%*	*67.9%*	*68.0%*	*70.7%*	*69.3%*	*68.7%*	*70.4%*	*68.9%*	*68.5%*	*66.8%*	*65.3%*
Fringe Benefits % of Salaries and Wages	*25.1%*	*26.6%*	*29.2%*	*29.1%*	*29.2%*	*28.2%*	*28.7%*	*27.3%*	*27.8%*	*28.2%*	*28.4%*

(1) Net of bad debt expense
(2) Supplies and Other and Physician Fees are combined in the historical periods

Financial Performance

ECHN Adjusted Revenue and EBITDAP

Revenue and EBITDA Adjustments

($ in thousands)

FYE September 30:	Audited Financial Statements 2010	2011	2012	2013	YTD February 28, 2013 (Internal)	2014 (Internal)	LTM 2/28/14	Management Projections 2014	2015	2016	2017
Revenue											
Total Revenue as Reported	$269,163	$269,884	$294,597	$327,968	$138,532	$141,109	$330,545	$329,559	$338,019	$349,492	$360,909
Less: Contributions	(1,748)	(732)	(2,243)	(1,614)	(580)	(548)	(1,583)	(1,500)	(1,500)	(1,500)	(1,500)
Less: JV Income	(2,250)	(1,806)	(2,796)	(2,161)	(929)	(983)	(2,215)	(2,182)	(2,225)	(2,270)	(2,315)
Less: Contribution of VNHSC	NA	NA	(4,592)	NA	NA	NA	NA	NA	NA	NA	NA
Plus: Full Year Revenue for VNHSC (1)	22,901	23,000	23,484	NA	NA	NA	NA	NA	NA	NA	NA
Less: Net Assets Released	(539)	(801)	(638)	(1,871)	(173)	(185)	(1,883)	(1,250)	(1,250)	(1,250)	(1,250)
Less: Grant Income	(2,249)	(3,075)	(2,600)	(2,102)	(906)	(1,025)	(2,221)	(2,434)	(2,434)	(2,434)	(2,434)
Less: Energy Rebate	NA	NA	NA	(1,218)	(439)	0	(779)	0	0	0	0
Less: Interest/Dividend Income and Realized Gains	(801)	(1,357)	(1,327)	(7,115)	(1,409)	(1,483)	(7,189)	(1,550)	(1,597)	(1,644)	(1,694)
Less: EHR Incentive Income	NA	(975)	(3,833)	(2,631)	(1,096)	(721)	(2,256)	(877)	(877)	0	0
Less: Rural Floor Adjustment	NA	NA	(1,621)	NA	NA	NA	NA	NA	NA	NA	NA
Adjusted Total Revenue	**$284,478**	**$284,138**	**$298,430**	**$309,255**	**$133,000**	**$136,164**	**$312,419**	**$319,766**	**$328,136**	**$340,394**	**$351,716**
% Growth		*-0.1%*	*5.0%*	*3.6%*	*NA*	*2.4%*	*NA*	*3.4%*	*2.6%*	*3.7%*	*3.3%*
EBITDAP											
EBITDA as Reported	$23,584	$16,166	$19,943	$16,311	$6,413	$6,409	$16,307	$16,945	$17,062	$22,397	$27,835
Plus (Less): Revenue Adjustments Above	15,314	14,254	3,833	(18,713)	(5,532)	(4,945)	(18,126)	(9,793)	(9,883)	(9,098)	(9,193)
Less: Full Year Expenses for VNHSC (1)	(21,444)	(22,059)	(22,203)	NA	NA	NA	NA	NA	NA	NA	NA
Plus: Certain Costs Related to Net Assets Released	270	401	319	936	86	92	942	625	625	625	625
Plus: Certain Costs Related to Grant Income	1,124	1,537	1,300	1,051	453	512	1,110	1,217	1,217	1,217	1,217
Plus: Est. Expenses related to Interest/Dividend Income	100	100	100	100	42	42	100	100	100	100	100
Plus: Estimated EHR Administrative Expenses	NA	250	250	250	104	104	250	250	250	0	0
Plus: Excess Captive Losses	NA	NA	2,584	4,443	0	0	4,443	NA	NA	NA	NA
Plus: Pension and PRMB Expense	1,295	2,266	5,119	3,491	2,528	224	1,187	1,797	1,309	1,002	405
Plus: Net Intercompany Eliminations	NA	NA	NA	0	224	50	(175)	NA	NA	NA	NA
Adjusted EBITDAP	**$20,244**	**$12,915**	**$11,244**	**$7,869**	**$4,318**	**$2,488**	**$6,038**	**$11,142**	**$10,680**	**$16,243**	**$20,989**
% Margin	*7.1%*	*4.5%*	*3.8%*	*2.5%*	*3.2%*	*1.8%*	*1.9%*	*3.5%*	*3.3%*	*4.8%*	*6.0%*
% Growth		*-36.2%*	*-12.9%*	*-30.0%*	*NA*	*-42.4%*	*NA*	*41.6%*	*-4.1%*	*52.1%*	*29.2%*

(1) Based on financial statements as of fiscal year end June 30.

Financial Performance

JV Investments Income and Distributions

JV Income and Distributions Summary

($ in thousands)

FYE September 30:	Actual 2010	2011	2012	2013	YTD February 28, 2013	2014	LTM 2/28/14
JV Investment Income (Not-for-Profit or Passthrough Entities):							
Tolland Imaging Center	($11)	($50)	$66	$28	$0	$50	$78
Northeast Regional Radiation Oncology Network, Inc. ("NRRON")(1)	643	(12)	472	362	150	200	412
Walden Behavioral Health	-	-	-	(2)	-	-	(2)
Ambulance Service of Manchester, LLC (2)	1,324	1,120	1,217	1,247	560	505	1,192
VNHSC	172	228	653	-	-	-	-
Haynes Street Medical Associates	3	42	(31)	24	7	19	36
Haynes Street Medical Associates II	(0)	(49)	56	33	16	29	46
Evergreen Medical Associates, LLC	16	24	17	87	11	24	100
Evergreen Medical Associates II, LLC	(35)	28	(51)	(0)	3	15	12
Evergreen Endoscopy Center, LLC	380	327	366	346	120	105	331
Medical Practice Partners, LLC	(336)	32	(125)	37	37	-	-
Evergreen Imaging	95	116	158	-	-	-	-
Pre-Tax Income (Not-for-Profit/Passthrough Entities)	$2,250	$1,806	$2,796	$2,161	$904	$947	$2,204
Estimated After-Tax Income (Not-for-Profit/Passthrough Entities)	$1,353	$1,086	$1,681	$1,299	$544	$569	$1,325
JV Investment Income (Taxable Entities):							
Metro Wheelchair Service Inc.	NA	NA	(42)	(30)	(25)	(17)	(22)
Aetna Ambulance Service Inc.	NA	NA	177	210	50	53	213
After-Tax Income (Taxable Entities)	NA	NA	135	180	25	36	191
Total JV Investment Income After-Tax	**$1,353**	**$1,086**	**$1,817**	**$1,479**	**$569**	**$605**	**$1,516**
JV Investment Distributions:							
Ambulance Service of Manchester	$900	$1,300	$1,050	$1,150	$300	$600	$1,450
Haynes Street Medical Associates	12	13	19	20	10	10	21
Haynes Street Medical Associates II	-	23	45	49	23	26	53
Evergreen Medical Associates, LLC	27	33	60	88	38	50	100
Evergreen Medical Associates II, LLC	5	18	36	46	23	23	46
Evergreen Endoscopy Center, LLC	200	525	350	450	250	250	450
Evergreen Imaging	9	60	95	-	-	-	-
NRRON Estimated Free Cash Flow (3)	NA	NA	206	533	NA	NA	533
Total Distributions	**$1,153**	**$1,972**	**$1,860**	**$2,336**	**$643**	**$960**	**$2,652**

(1) Fiscal 2013 income reflects 50% of the change in net assets as reported on NRRON's audited financial statements.
(2) Includes income from Metro Wheelchair Service Inc. and Aetna Ambulance Service Inc. in fiscal 2010 and 2011.
(3) Based on NRRON audited financial statements as of September 30, 2013; represents cash generated by operating activies minus capital expenditures

V. Valuation Analysis

Valuation Analysis

Discounted Cash Flow Analysis

- In performing the DCF analysis, we relied on the Management Projections from FY 2014 through 2017. Duff & Phelps extended the projections based on discussions with Management through FY 2019 using an estimated revenue growth rate of 3.0% and stable margins.
  - Adjusted Revenue was estimated to grow at a compounded annual growth rate of 2.4% from FY 2014 through 2017.
  - Adjusted EBITDAP margins was estimated to increase from 3.5% in FY 2014 to 6.0% in FY 2017.
  - Capital expenditures are estimated to be between 3.2% and 3.6% of revenues from FY 2014 through 2017.
- Our DCF utilized a weighted cost of capital ("WACC") range of 10.5% to 11.5% to discount the unlevered free cash flows of ECHN.
- As a not-for-profit entity, the Company does not pay taxes; however, standard valuation practices dictate that we determine the value of the Company as if it were a taxable corporation. Therefore a tax rate of 39.9% is applied in our analysis based on currently prevailing federal and the state of Connecticut's corporate income tax rates.

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Valuation Analysis

Discounted Cash Flow Analysis

Discounted Cash Flow Analysis

($ in thousands)

	Management Projections				*Long-Term Projections*		6-Year
	2014	2015	2016	2017	2018	2019	CAGR
Adjusted Revenue	$319,766	$328,136	$340,394	$351,716	$362,267	$373,135	3.2%
Growth	*3.4%*	*2.6%*	*3.7%*	*3.3%*	*3.0%*	*3.0%*	
Adjusted EBITDAP	11,142	10,680	16,243	20,989	21,617	22,263	29.7%
EBITDAP Margin	*3.5%*	*3.3%*	*4.8%*	*6.0%*	*6.0%*	*6.0%*	
EBITDAP Growth	*41.6%*	*(4.1%)*	*52.1%*	*29.2%*	*3.0%*	*3.0%*	
	Partial Period (1)						
Earnings Before Interest and Taxes (2)	$1,732	($1,620)	$3,943	$8,689	$10,287	$10,593	
Pro Forma Taxes @ 39.9%	(691)	0	(1,572)	(3,465)	(4,102)	(4,224)	
Net Operating Profit After Tax	1,041	(1,620)	2,371	5,225	6,185	6,369	
Depreciation	6,932	12,300	12,300	12,300	11,330	11,670	
Capital Expenditures	(7,719)	(11,000)	(11,000)	(11,000)	(11,330)	(11,670)	
(Increase) Decrease in Working Capital	429	1,144	(1,605)	(1,448)	(795)	(818)	
Free Cash Flow	$683	$824	$2,065	$5,076	$5,391	$5,550	
Terminal Growth Rate	3.0%	3.0%	3.0%				
Weighted Average Cost of Capital	11.5%	11.0%	10.5%				
Concluded Enterprise Value Range (Rounded) (3)	$52,700	$56,200	$60,300				

Implied Enterprise Value Multiples

2013 Adjusted EBITDAP	$7,869	6.7x	7.1x	7.7x
Proj. 2014 Adjusted EBITDAP	$11,142	4.7x	5.0x	5.4x
2013 Adjusted Revenue	$309,255	0.2x	0.2x	0.2x

(1) Represents the period from March 1st through December 31
(2) Adjusted to include projected income from reimbursment related to the EHR conversion, net of expenses
(3) Includes the present value of net operating loss carryforwards generated in fiscal 2015

Valuation Analysis

M&A Transactions Analysis Summary

Nonprofit Hospital Transactions - Summary Tables

	EBITDA Margin			Number of Beds			Committed Capital	
	< 5%	5% - 10%	> 10%	< 200	200 - 400	> 400	No	Yes
Implied EV / EBITDA Multiples								
Average	11.4x	9.5x	5.4x	7.3x	11.0x	4.6x	11.5x	6.2x
Median	10.4x	9.4x	4.1x	7.0x	12.2x	4.1x	12.0x	4.8x
1st Quartile	8.2x	6.8x	2.3x	6.2x	7.7x	2.2x	8.2x	2.2x
3rd Quartile	16.3x	12.0x	4.8x	8.4x	16.2x	4.8x	14.5x	8.8x
Observations	7	9	9	8	12	5	11	14
Implied EV / Revenue Multiples								
Average	0.47x	0.66x	0.63x	0.49x	0.57x	0.66x	0.68x	0.41x
Median	0.35x	0.60x	0.45x	0.40x	0.60x	0.75x	0.63x	0.35x
1st Quartile	0.23x	0.49x	0.35x	0.23x	0.25x	0.40x	0.32x	0.21x
3rd Quartile	0.69x	0.78x	0.57x	0.61x	0.78x	0.85x	0.90x	0.54x
Observations	19	9	9	20	19	11	27	23
Implied Price / Beds								
Average	$362	$548	$490	$453	$347	$569	$481	$386
Median	$239	$479	$521	$429	$308	$456	$480	$308
1st Quartile	$133	$476	$285	$154	$179	$282	$200	$130
3rd Quartile	$478	$683	$652	$653	$479	$695	$683	$479
Observations	19	9	9	22	19	11	29	23

Valuation Analysis

Selected Public Companies – Financial Performance

Selected Public Company Analysis — **April 7, 2014**

($ in millions, except per share data)

COMPANY INFORMATION	REVENUE GROWTH				EBITDAP GROWTH				EBITDAP MARGIN			
Company Name	3-YR CAGR	LTM	2014	2015	3-YR CAGR	LTM	2014	2015	3-YR AVG	LTM	2014	2015
Community Health Systems, Inc.	5.4%	-0.2%	48.5%	7.2%	-0.9%	29.3%	68.0%	10.4%	15.0%	19.6%	15.5%	15.9%
HCA Holdings, Inc.	6.8	3.5	5.2	4.9	5.5	0.4	3.8	5.9	20.9	20.5	20.3	20.4
HEALTHSOUTH Corp.	6.5	5.3	5.7	4.9	10.9	11.7	1.2	6.1	24.2	25.4	24.3	24.6
Kindred Healthcare Inc.	4.1	-0.6	5.2	3.5	9.4	-20.5	37.5	6.2	6.3	5.8	7.6	7.8
Lifepoint Hospitals Inc.	9.3	8.4	9.1	6.6	-1.7	-8.0	17.2	6.5	15.8	13.7	14.7	14.7
Select Medical Holdings Corporation	7.7	1.0	4.1	2.9	5.4	-8.3	1.3	2.8	13.6	12.7	12.4	12.4
Tenet Healthcare Corp.	10.3	21.7	43.3	5.2	9.0	45.4	37.0	11.4	13.3	16.4	12.0	12.7
Universal Health Services Inc.	14.1	4.6	8.0	5.5	19.7	5.2	-0.2	8.1	18.6	19.0	17.6	18.0
Mean	8.0%	5.5%	16.1%	5.1%	7.2%	6.9%	20.7%	7.2%	16.0%	16.6%	15.5%	15.8%
Median	7.3%	4.1%	6.8%	5.1%	7.2%	2.8%	10.5%	6.4%	15.4%	17.7%	15.1%	15.3%
Eastern Connecticut Health Network	2.8%	2.4%	3.4%	2.6%	-26.8%	-42.4%	40.2%	-4.1%	3.6%	2.0%	3.5%	3.3%

LTM = Latest Twelve Months
CAGR = Compounded Annual Growth Rate
Enterprise Value = (Market Capitalization) + (Debt + Preferred Stock + Minority Interest) - (Cash & Equivalents)
EBITDAP = Earnings Before Interest, Taxes, Depreciation, Amortization, and Pension Expense
Source: Bloomberg, Capital IQ, SEC filings

Valuation Analysis

Selected Public Companies – Valuation Metrics

Selected Public Company Analysis — **April 7, 2014**

($ in millions, except per share data)

COMPANY INFORMATION	MARKET DATA			ENTERPRISE VALUE AS MULTIPLE OF					COMMON STOCK PRICE AS A MULTIPLE OF			
Company Name	Stock Price	% of 52-Wk High	Enterprise Value	LTM EBITDAP	2014 EBITDAP	2015 EBITDAP	LTM Revenue	2014 Revenue	LTM EPS	2014 EPS	2015 EPS	Licensed Bed ($000)
Community Health Systems, Inc.	$37.04	72.4%	$21,427	8.4x	7.2x	6.5x	1.65x	1.11x	15.3x	11.9x	9.5x	$1,062
HCA Holdings, Inc.	48.76	92.9	51,994	7.4	7.1	6.7	1.52x	1.45x	14.3	13.3	11.6	1,212
HEALTHSOUTH Corp.	34.75	95.3	4,796	8.4	8.3	7.8	2.13x	2.02x	14.1	18.2	17.0	703
Kindred Healthcare Inc.	24.04	100.2	2,815	9.9	7.2	6.8	0.57x	0.55x	NM	20.9	18.6	137
Lifepoint Hospitals Inc.	52.92	93.9	4,369	8.7	7.4	7.0	1.19x	1.09x	19.7	20.0	17.6	634
Select Medical Holdings Corporation	13.13	102.4	3,353	9.0	8.8	8.6	1.14x	1.10x	14.6	14.4	13.3	648
Tenet Healthcare Corp.	40.15	81.5	15,045	8.3	7.9	7.1	1.36x	0.95x	24.6	29.9	17.6	741
Universal Health Services Inc.	77.85	90.7	11,242	8.1	8.1	7.5	1.54x	1.43x	15.1	15.6	14.0	440
Mean	$41.08	91.2%	$14,380	8.5x	7.8x	7.3x	1.39x	1.21x	16.8x	18.0x	14.9x	$697
Median	$38.60	93.4%	$8,019	8.4x	7.6x	7.0x	1.44x	1.10x	15.1x	16.9x	15.5x	$675

LTM = Latest Twelve Months
CAGR = Compounded Annual Growth Rate
Enterprise Value = (Market Capitalization) + (Debt + Preferred Stock + Minority Interest) - (Cash & Equivalents)
EBITDAP = Earnings Before Interest, Taxes, Depreciation, Amortization, and Pension Expense
Source: Bloomberg, Capital IQ, SEC filings

Valuation Analysis

Market Approach

Market Approach - Company

($ in thousands)

Enterprise Valuation Multiples				Valuation Summary		
Metric	Public Company Range	Public Company Median	M&A Transactions Median (1)	Selected Multiple Range	Company Performance	Enterprise Value Range
Proj. 2014 Adjusted EBITDAP	7.1x - 8.8x	7.6x	7.2x	**5.0x - 6.0x**	$11,142	$55,709 - $66,851
				Concluded Value Range (Rounded)		**$55,700 - $66,900**
				Implied Enterprise Value Multiples		
				2013 Adjusted EBITDAP	$7,869	7.1x - 8.5x
				Price Per Bed ($000s) (2)	327	$170 - $205
				2013 Adjusted Revenue	$309,255	0.18x - 0.22x

(1) LTM EBITDA multiple

(2) Includes staffed, psychiatric, and skilled nursing beds

Valuation Analysis

JV Investments

JV Investments Valuation

($ in thousands)

Market Approach			
LTM JV Income After Tax (1)	$1,516	$1,516	$1,516
Selected Multiple Range	10.0x	11.0x	12.0x
Estimated Range of Value (Rounded)	**$15,200**	**$16,700**	**$18,200**
Gordon Growth Approach			
After-Tax Estimated LTM Distributions (2)	$1,595	$1,595	$1,595
Estimated Range of Discount Rate	13.75%	13.25%	12.75%
Estimated Perpetuity Growth Rate	3.0%	3.0%	3.0%
Estimated Range of Value (Rounded)	**$15,280**	**$16,026**	**$16,847**
Estimated Value of JV Investments	**$15,200**	**$16,400**	**$17,500**

(1) LTM as of February 28, 2014
(2) JV Investments income and distributions burdened with taxes at an estimated rate of 39.9% and includes an adjustment for estimated free cash flow from NRRON

Appendix

M&A Transaction Detail

M&A Transaction Detail

Nonprofit Hospital Transactions

	Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
	2/28/2014	Mercy Regional Health Center	Kansas	Via Christi Health	-	$15.5	$92.3	$12.9	13.9%	111	NA	NA	NA
	1/29/2014	Hackettstown Regional Medical Center	New Jersey	Atlantic Health System	$54.0	-	89.7	7.5	8.3%	103	0.60x	7.2x	524
	1/8/2014	Wilson Medical Center	North Carolina	Duke LifePoint Healthcare, LLC	-	120.0	141.4	25.1	17.8%	274	NA	NA	NA
	12/30/2013	Casa Grande Community Hospital	Arizona	Banner Health	87.0	-	138.6	NA	NA	174	0.63x	NA	500
	10/31/2013	WestCare	North Carolina	Duke LifePoint Healthcare, LLC	26.3	36.0	96.0	(4.3)	-4.5%	110	0.27x	NM	239
	10/25/2013	Oak Park Hospital	Illinois	Rush University Medical Center	21.1	-	107.5	2.3	2.1%	237	0.20x	9.2x	89
(1)	8/6/2013	Portage Health	Michigan	LifePoint Hospitals, Inc.	50.0	60.0	87.4	10.4	11.9%	96	0.57x	4.8x	521
	7/11/2013	Stanly Health Services	North Carolina	Carolinas HealthCare System	-	70.0	134.7	14.1	10.5%	119	NA	NA	NA
	6/23/2013	Altoona Regional Health System	Pennsylvania	UPMC Health System	131.8	250.0	372.7	61.0	16.4%	402	0.35x	2.2x	328
	4/19/2013	St. Luke's Episcopal Health System	Texas	Catholic Health Initiatives	1,000.0	1,000.0	1,275.7	26.5	2.1%	1,098	0.78x	NM	911
	3/28/2013	Two Kansas Hospital	Kansas	Prime Healthcare Services	54.3	-	184.8	(8.8)	-4.8%	232	0.29x	NM	234
	3/8/2013	Cleveland County HealthCare System	North Carolina	Carolinas HealthCare System	101.0	-	222.3	24.8	11.1%	504	0.45x	4.1x	200
	1/2/2013	Knapp Medical Center	Texas	Prime Healthcare Foundation	100.0	10.0	128.6	8.2	6.4%	209	0.78x	12.2x	478
	12/13/2012	New York Westchester Square Medical	New York	Montefiore Medical Center	14.0	-	75.7	(2.4)	-3.1%	140	0.18x	NM	100
	12/10/2012	Medical Center of Newark	Ohio	Licking Memorial Health Systems	26.0	-	18.2	(0.2)	-0.9%	20	1.43x	NM	1,300
	11/29/2012	St. Mary's Hospital	New Jersey	Prime Healthcare Services	25.0	44.0	166.4	1.3	0.8%	279	0.15x	19.2x	90
	11/14/2012	University of Louisville Hospital	Kentucky	KentuckyOne Health	-	1,394.0	450.6	10.9	2.4%	345	NA	NA	NA
	11/5/2012	North Texas Community Hospital	Texas	Wise Regional Health System	20.0	-	NA	NA	NA	21	NA	NA	952
	10/19/2012	St. Vincent's Health System	Pennsylvania	HighMark, Inc.	20.0	45.0	327.4	15.3	4.7%	400	0.06x	1.3x	50
	10/10/2012	Chilton Hospital	New Jersey	Atlantic Health System	43.0	-	166.9	(2.9)	-1.7%	260	0.26x	NM	165

(1) Purchase price was grossed up to reflect an acquisition of 100% of the implied enterprise value
Source: Irving Levin Associates and Standard & Poor's Capital IQ

M&A Transaction Detail

Nonprofit Hospital Transactions

	Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
	8/27/2012	Hawaii Medical Center - West Campus	Hawaii	Queen's Health Systems	70.0	-	NA	NA	NA	102	NA	NA	686
	7/1/2012	Fox Chase Cancer Center	Pennsylvania	Temple University Health System	83.8	30.9	236.6	36.5	15.4%	100	0.35x	2.3x	838
	6/12/2012	Jefferson Regional Medical Center	Pennsylvania	HighMark, Inc.	275.0	-	204.7	22.6	11.0%	376	1.34x	12.2x	731
	6/1/2012	Westerly Hospital	Rhode Island	Lawrence & Memorial Hospital	69.0	-	90.6	5.8	6.4%	101	0.76x	12.0x	683
	5/3/2012	Cheboygan Memorial Hospital	Michigan	McLaren Health Care	5.0	-	45.9	(7.4)	-16.1%	91	0.11x	NM	55
	4/3/2012	Bay Medical Center	Florida	Sacred Heart Health System, Inc.	154.0	-	258.4	9.5	3.7%	323	0.60x	16.2x	477
	3/27/2012	Christ Hospital	New Jersey	Hudson Hospital Holdco, Inc.	43.5	-	125.1	1.4	1.1%	227	0.35x	NM	192
	3/6/2012	Marquette General Health System	Michigan	Duke LifePoint Healthcare, LLC	147.0	328.0	244.2	15.6	6.4%	307	0.60x	9.4x	479
	3/1/2012	Satilla Health Services	Georgia	Mayo Clinic Health System	-	51.0	152.8	4.2	2.7%	231	NA	NA	NA
(1)	2/3/2012	Integris Health joint venture	Oklahoma	Health Management Associates, Inc.	75.0	-	96.5	1.8	1.8%	226	0.78x	NM	332
	1/24/2012	Memorial Health Systems	Pennsylvania	Community Health Systems, Inc.	47.6	75.0	97.0	7.1	7.3%	100	0.49x	6.7x	476
	12/15/2011	Alamance Regional Medical Center	North Carolina	Cone Health	50.0	150.0	213.9	23.6	11.0%	218	0.23x	2.1x	229
	12/7/2011	Virginia Regional Medical Center	Minnesota	Essentia Health	10.0	17.0	50.7	NA	NA	164	0.20x	NA	61
	11/1/2011	Leake Memorial Hospital	Mississippi	Baptist Health System	2.8	-	11.7	NA	NA	25	0.24x	NA	110
(1)	10/27/2011	Twin County Regional Hospital	Virginia	Duke LifePoint Healthcare, LLC	12.5	20.0	55.0	NA	NA	86	0.23x	NA	145
	9/29/2011	Bay Medical Center	Florida	LHP Hospital Group, Inc.	155.0	-	258.4	9.5	3.7%	323	0.60x	16.3x	480
	9/6/2011	Mercy Hospital & Medical Center	Illinois	Trinity Health	26.0	150.0	251.4	15.3	6.1%	449	0.10x	1.7x	58
	9/1/2011	Logan Medical Center	Oklahoma	Mercy	7.2	-	22.3	1.0	4.5%	25	0.32x	7.2x	288
	7/28/2011	Tomball Regional Medical Center	Texas	Community Health Systems, Inc.	225.4	-	151.0	17.6	11.7%	358	1.49x	12.8x	630
	7/19/2011	Moses Taylor Health Care System	Pennsylvania	Community Health Systems, Inc.	172.4	-	148.8	9.5	6.4%	242	1.16x	18.1x	712

(1) Purchase price was grossed up to reflect an acquisition of 100% of the implied enterprise value
Source: Irving Levin Associates and Standard & Poor's Capital IQ

M&A Transaction Detail

Nonprofit Hospital Transactions

	Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
	7/1/2011	Mercy Health Partners	Tennessee	Health Management Associates, Inc.	532.4	-	600.0	22.8	3.8%	833	0.89x	NM	639
	6/28/2011	Quincy Medical Center	Massachusetts	Steward Health Care System	35.0	44.0	78.1	1.5	1.9%	196	0.45x	NM	179
	6/25/2011	West Penn Allegheny Health System	Pennsylvania	HighMark, Inc.	1,475.0	-	1,600.0	33.3	2.1%	2,000	0.92x	NM	738
	6/7/2011	Landmark Medical Center	Rhode Island	Steward Health Care System	23.1	53.5	122.3	NA	NA	203	0.19x	NA	114
	5/25/2011	Civista Health System	Maryland	University of Maryland Medical System	4.0	12.5	103.8	NA	NA	130	0.04x	NA	31
	5/10/2011	Twin City Hospital	Ohio	Franciscan Services Corp.	4.9	-	15.5	NA	NA	25	0.32x	NA	196
	4/27/2011	Alexian Brothers Health System	Illinois	Ascension Health	490.0	155.0	952.6	101.9	10.7%	752	0.51x	4.8x	652
	4/25/2011	Hoboken University Medical System	New Jersey	HUMC Holdco, LLC	70.8	20.9	115.3	NA	NA	230	0.61x	NA	308
	4/18/2011	Sierra Kings District Hospital	California	Adventist Health	24.8	-	22.1	NA	NA	44	1.12x	NA	564
	3/31/2011	Morton Hospital and Medical Center	Massachusetts	Steward Health Care System	58.5	120.0	127.3	8.6	6.8%	153	0.46x	6.8x	382
	3/25/2011	Hospital of Saint Raphael	Connecticut	Yale-New Haven Hospital	160.0	135.0	450.3	15.4	3.4%	511	0.36x	10.4x	313
	3/22/2011	St. Mary's Hospital	Connecticut	LHP Hospital Group, Inc.	200.0	-	201.4	17.1	8.5%	175	0.99x	11.7x	1,143
(1)	3/18/2011	St. Joseph Medical Center	Texas	Iasis Healthcare, LLC	198.2	-	245.0	NA	NA	792	0.81x	NA	250
	3/7/2011	Loyola University Health System	Illinois	Trinity Health	1,405.0	375.0	1,100.0	NA	NA	820	1.28x	NA	1,713
(1)	2/16/2011	Valley Baptist Health System	Texas	Vanguard Health Systems, Inc.	394.9	-	527.0	NA	NA	866	0.75x	NA	456
	2/10/2011	Mercy Health Partners	Pennsylvania	Community Health Systems, Inc.	161.0	-	183.9	NA	NA	313	0.88x	NA	514
	2/1/2011	Hamot Medical Center	Pennsylvania	UPMC Health System	100.0	200.0	315.2	33.0	10.5%	351	0.32x	3.0x	285
				Median	$54.0		$148.8	$10.0	5.4%	227	0.48x	7.2x	$357

(1) Purchase price was grossed up to reflect an acquisition of 100% of the implied enterprise value
Source: Irving Levin Associates and Standard & Poor's Capital IQ

EXHIBIT 14 – DUFF & PHELPS' FAIRNESS OPINION LETTER

DUFF & PHELPS

Confidential

April 9, 2014

Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Ladies and Gentlemen:

Eastern Connecticut Health Network, Inc. and its wholly owned subsidiaries (collectively, the "Company") has engaged Duff & Phelps, LLC ("Duff & Phelps") to serve as an independent financial advisor to the board of trustees (collectively the "Board of Trustees") of the Company and to provide an opinion (the "Opinion") as of the date hereof as to the fairness, from a financial point of view, to the Company of the consideration to be received by the Company in the contemplated transaction described below (the "Proposed Transaction").

Description of the Proposed Transaction

It is Duff & Phelps' understanding that the Proposed Transaction involves the sale of substantially all of the assets of the Company and substantially all of the assets of the Company's subsidiaries, other than cash and investments, to a third-party buyer for cash consideration in the amount of $105 million, subject to adjustment for certain assumed liabilities and other items as more fully described in the Asset Purchase Agreement (as defined below). It is our further understanding that the buyer will make certain post-closing covenants with respect to the continued provision of medical services as well as a minimum level of future capital investment.

Scope of Analysis

In connection with this Opinion, Duff & Phelps has made such reviews, analyses and inquiries as it has deemed necessary and appropriate under the circumstances. Duff & Phelps also took into account its assessment of general economic, market and financial conditions, as well as its experience in securities and business valuation, in general, and with respect to similar transactions, in particular. Duff & Phelps' procedures, investigations, and financial analysis with respect to the preparation of its Opinion included, but were not limited to, the items summarized below:

Duff & Phelps, LLC
10100 Santa Monica Boulevard
Suite 1100
Los Angeles, CA 90067

T +1 424 249 1650
F +1 424 249 1651

www.duffandphelps.com

1. Reviewed the following documents:

   a. The Company's consolidated audited financial statements for the years ended September 30, 2010 through 2013 and the Company's unaudited interim financial statements for the five-month periods ended February 28, 2013 and 2014;

   b. Other internal documents relating to the history, current operations, and probable future outlook of the Company, including financial projections, provided to us by management of the Company; and

   c. Documents related to the Proposed Transaction, including the draft Asset Purchase Agreement, date April 8, 2014 by and between Eastern Connecticut Health Network, Inc. and VHS Eastern Connecticut Health System, LLC (the "Asset Purchase Agreement");

2. Discussed the information referred to above and the background and other elements of the Proposed Transaction with the management of the Company;

3. Performed certain valuation and comparative analyses using generally accepted valuation and analytical techniques including a discounted cash flow analysis, an analysis of selected public companies that Duff & Phelps deemed relevant, and an analysis of selected transactions that Duff & Phelps deemed relevant; and

4. Conducted such other analyses and considered such other factors as Duff & Phelps deemed appropriate.

Assumptions, Qualifications and Limiting Conditions

In performing its analyses and rendering this Opinion with respect to the Proposed Transaction, Duff & Phelps, with the Company's consent:

1. Relied upon the accuracy, completeness, and fair presentation of all information, data, advice, opinions and representations obtained from public sources or provided to it from private sources, including Company management, and did not independently verify such information;

2. Relied upon the fact that the Board of Trustees and the Company have been advised by counsel as to all legal matters with respect to the Proposed Transaction, including whether all procedures required by law to be taken in connection with the Proposed Transaction have been duly, validly and timely taken;

3. Assumed that any estimates, evaluations, forecasts and projections furnished to Duff & Phelps were reasonably prepared and based upon the best currently available information and good faith judgment of the person furnishing the same;

4. Assumed that information supplied and representations made by Company management are substantially accurate regarding the Company and the Proposed Transaction

5. Assumed that the representations and warranties made in Asset Purchase Agreement are substantially accurate;

6. Assumed that the final versions of all documents reviewed by Duff & Phelps in draft form conform in all material respects to the drafts reviewed;

7. Assumed that there has been no material change in the assets, financial condition, business, or prospects of the Company since the date of the most recent financial statements and other information made available to Duff & Phelps;

8. Assumed that all of the conditions required to implement the Proposed Transaction will be satisfied and that the Proposed Transaction will be completed in accordance with the Agreement without any amendments thereto or any waivers of any terms or conditions thereof;

9. Assumed that all governmental, regulatory or other consents and approvals necessary for the consummation of the Proposed Transaction will be obtained without any adverse effect on the Company; and

10. Assumed that any reduction in the amount of consideration to be received by the Company as a result of the separate sale of any joint venture or other equity interests held by the Company is not materially greater than the consideration received by the Company in such separate sale.

To the extent that any of the foregoing assumptions or any of the facts on which this Opinion is based prove to be untrue in any material respect, this Opinion cannot and should not be relied upon. Furthermore, in Duff & Phelps' analysis and in connection with the preparation of this Opinion, Duff & Phelps has made numerous assumptions with respect to industry performance, general business, market and economic conditions and other matters, many of which are beyond the control of any party involved in the Proposed Transaction.

Duff & Phelps has prepared this Opinion effective as of the date hereof. This Opinion is necessarily based upon market, economic, financial and other conditions as they exist and can be evaluated as of the date hereof, and Duff & Phelps disclaims any undertaking or obligation to advise any person of any change in any fact or matter affecting this Opinion which may come or be brought to the attention of Duff & Phelps after the date hereof.

Duff & Phelps did not evaluate the Company's solvency or conduct an independent appraisal or physical inspection of any specific assets or liabilities (contingent or otherwise). Duff & Phelps has not been requested to, and did not: (i) initiate any discussions with, or solicit any indications of interest from, third parties with respect to the Proposed Transaction, the assets, businesses or

operations of the Company, or any alternatives to the Proposed Transaction, (ii) negotiate the terms of the Proposed Transaction, and therefore, Duff & Phelps has assumed that such terms are the most beneficial terms, from the Company's perspective, that could, under the circumstances, be negotiated among the parties to the Asset Purchase Agreement and the Transaction, or (iii) advise the Board of Directors or any other party with respect to alternatives to the Proposed Transaction. Duff & Phelps was not requested to and did not determine the Company's value under any liquidation scenario, including the potential proceeds that might be obtained therefrom.

This Opinion should not be construed as a valuation opinion, credit rating, solvency opinion, an analysis of the Company's credit worthiness, as tax advice, or as accounting advice. Duff & Phelps has not made, and assumes no responsibility to make, any representation, or render any opinion, as to any legal matter.

In rendering this Opinion, Duff & Phelps is not expressing any opinion with respect to the amount or nature of any compensation to any of the Company's officers, directors, or employees, or any class of such persons, relative to the consideration to be received by the Company in the Proposed Transaction, or with respect to the fairness of any such compensation.

This Opinion is furnished solely for the use and benefit of the Company, its corporators and the Board of Trustees in connection with its consideration of the Proposed Transaction and is not intended to, and does not, confer any rights or remedies upon any other person, and is not intended to be used, and may not be used, by any other person or for any other purpose, without Duff & Phelps' express consent. This Opinion: (i) does not address the merits of the underlying business decision to enter into the Proposed Transaction versus any alternative strategy or transaction; (ii) does not address any transaction related to the Proposed Transaction; (iii) is not a recommendation as to how the Board of Trustees, any corporator or any other party should vote or act with respect to any matters relating to the Proposed Transaction, or whether to proceed with the Proposed Transaction or any related transaction, and (iv) does not indicate that the consideration received is the best possibly attainable under any circumstances; instead, it merely states whether the consideration in the Proposed Transaction is within a range suggested by certain financial analyses. The decision as to whether to proceed with the Proposed Transaction or any related transaction may depend on an assessment of factors unrelated to the financial analysis on which this Opinion is based. This letter should not be construed as creating any fiduciary duty on the part of Duff & Phelps to any party.

This Opinion is solely that of Duff & Phelps, and Duff & Phelps' liability in connection with this letter shall be limited in accordance with the terms set forth in the engagement letter between Duff & Phelps and the Company dated October 31, 2013 (the "Engagement Letter"). This letter is confidential, and its use and disclosure is strictly limited in accordance with the terms set forth in the Engagement Letter.

Disclosure of Prior Relationships

Duff & Phelps has acted as financial advisor to the Board of Directors and will receive a fee for its services. No portion of Duff & Phelps' fee is contingent upon either the conclusion expressed in this Opinion or whether or not the Proposed Transaction is successfully consummated. Pursuant to the terms of the Engagement Letter, a portion of Duff & Phelps' fee is payable upon Duff & Phelps' informing the Company that it is prepared to deliver its Opinion. Other than this engagement, during the two years preceding the date of this Opinion, Duff & Phelps has not had any material relationship with any party to the Proposed Transaction for which compensation has been received or is intended to be received, nor is any such material relationship or related compensation mutually understood to be contemplated.

Conclusion

Based upon and subject to the foregoing, Duff & Phelps is of the opinion that as of the date hereof the consideration to be received by the Company in the Proposed Transaction is fair from a financial point of view to the Company.

This Opinion has been approved by the Opinion Review Committee of Duff & Phelps.

Respectfully submitted,

Duff & Phelps, LLC

Duff & Phelps, LLC

EXHIBIT 15 – TENET'S 2013 10-K

Morningstar® Document Research℠

FORM 10-K

TENET HEALTHCARE CORP - THC

Filed: February 24, 2014 (period: December 31, 2013)

Annual report with a comprehensive overview of the company

The information contained herein may not be copied, adapted or distributed and is not warranted to be accurate, complete or timely. The user assumes all risks for any damages or losses arising from any use of this information, except to the extent such damages or losses cannot be limited or excluded by applicable law. Past financial performance is no guarantee of future results.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-K

☒ **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

for the fiscal year ended December 31, 2013

OR

☐ **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

for the transition period from to

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

Nevada	**95-2557091**
(State of Incorporation)	(IRS Employer Identification No.)

1445 Ross Avenue, Suite 1400
Dallas, TX 75202
(Address of principal executive offices, including zip code)

(469) 893-2200
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common stock, $0.05 par value	New York Stock Exchange
9 7/8% Senior Notes due 2014	New York Stock Exchange
9 1/4% Senior Notes due 2015	New York Stock Exchange
6 7/8% Senior Notes due 2031	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the preceding 12 months, and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate website every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Exchange Act Rule 12b-2).

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

As of June 30, 2013, the aggregate market value of the shares of common stock held by non-affiliates of the Registrant (treating directors, executive officers who were SEC reporting persons, and holders of 10% or more of the common stock outstanding as of that date, for this purpose, as affiliates) was approximately $3.9 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on Friday, June 28, 2013. As of January 31, 2014, there were 96,989,632 shares of common stock

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outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2014 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

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PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is an investor-owned company whose subsidiaries and affiliates operate regionally focused, integrated health care delivery networks with a significant presence in several large urban and suburban markets. At the core of our networks are acute care and specialty hospitals that, together with our strategically aligned outpatient facilities and related businesses, allow us to provide a comprehensive range of health care services in the communities we serve. As of December 31, 2013, we primarily operated 77 hospitals, 183 outpatient centers, six health plans, six accountable care networks and Conifer Health Solutions, LLC ("Conifer"), which provides business process solutions to more than 700 hospital and other clients nationwide. On October 1, 2013, we completed our previously announced acquisition of Vanguard Health Systems, Inc. ("Vanguard"), an investor-owned hospital company whose operations complemented our existing business. Through this acquisition, we significantly increased our scale, became more geographically diverse, and expanded the services we offer.

With respect to our hospitals and outpatient facilities, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology to remain competitive, to recruit and retain physicians, to expand our outpatient business, and to negotiate favorable contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communications and engagement solutions to optimize the relationship between providers and patients. In addition, our management services offerings have expanded to support value-based performance through clinical integration, financial risk management and population health management. For financial reporting purposes, our business lines are classified into two separate reportable business segments — hospital operations and other, and Conifer. Financial and statistical information about our business segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

We are committed to providing the communities our hospitals, outpatient centers and other health care facilities serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our shareholders. Our operating strategies for accomplishing this mission in the complex and competitive health care industry are discussed in detail in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. In general, we anticipate the continued acceleration of major industry trends we have seen emerge over the last several years, and our strategies reflect the belief that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically and financially; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of an improved economy, shifting demographics and the expansion of coverage under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act"); and (5) payer reimbursements will be constrained and further shift to being more closely tied to performance on quality and service metrics. We believe that our strategies and the acceleration of these trends will allow us to achieve our operational and financial targets. We adjust our strategies as necessary in response to changes in the economic and regulatory climates in which we operate and the results achieved by our various efforts.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER

Hospitals, Outpatient Centers and Related Businesses—At December 31, 2013, our subsidiaries operated 77 hospitals, including four academic medical centers, two children's hospitals, three specialty hospitals and a critical access hospital, with a total of 20,293 licensed beds, serving primarily urban and suburban communities in 14 states. Of those hospitals, 72 were owned by our subsidiaries, and five were owned by third parties and leased by our subsidiaries. We are also in the process of constructing the new Resolute Health Hospital and Wellness Campus in New Braunfels, Texas, which is expected to be completed in or around May 2014. In addition, at December 31, 2013, our subsidiaries operated a long-term acute care hospital and owned or leased and operated a number of medical office buildings, all of which were located on, or nearby, our hospital campuses. Furthermore, our subsidiaries operated 183 free-standing and provider-based outpatient centers in 16 states at

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December 31, 2013, including diagnostic imaging centers, ambulatory surgery centers, urgent care centers and satellite emergency departments, among others. We also owned over 500 physician practices at December 31, 2013.

We seek to operate our hospitals, outpatient centers and related businesses in a manner that positions them to compete effectively in an evolving health care environment. From time to time, we build new hospitals and outpatient centers, and make strategic acquisitions of hospitals, outpatient businesses, physician practices, and other health care assets and companies — in each case in markets where we believe our operating strategies can improve performance and create shareholder value. We believe that growth by strategic acquisitions, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. Moreover, we continually evaluate collaboration opportunities with outpatient facilities, health care providers, physician groups and others in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality service across the care continuum. During the year ended December 31, 2013, we acquired 28 hospitals (plus the New Braunfels hospital under construction) and 39 outpatient centers, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. In addition, in May 2013, we entered into a partnership with John Muir Health through which we will jointly develop and expand outpatient services and physician relationships to improve the efficiency and coordination of care in the Tri-Valley area and nearby communities in Northern California. Furthermore, we have signed a definitive agreement to acquire Emanuel Medical Center, a 209-bed hospital located in Turlock, California. We also sometimes decide to sell, consolidate or close certain facilities to eliminate duplicate services or excess capacity or because of changing market conditions or other factors.

Our hospitals classified in continuing operations for financial reporting purposes generated in excess of 90% of our net operating revenues before provision for doubtful accounts for all periods presented in our Consolidated Financial Statements. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related health care facilities include, but are not limited to: (1) the business environment, economic conditions and demographics of local communities in which we operate; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local health care competitors; (8) managed care contract negotiations or terminations; (9) the number of patients with high-deductible health insurance plans; (10) any unfavorable publicity about us that impacts our relationships with physicians and patients; (11) changes in health care regulations and the participation of individual states in federal programs; and (12) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most offer intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals also offer tertiary care services such as open-heart surgery, neonatal intensive care and neurosciences. Five of our hospitals — Good Samaritan Medical Center, Hahnemann University Hospital, Harper University Hospital, North Shore Medical Center and St. Louis University Hospital — offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Children's Hospital of Michigan and St. Christopher's Hospital for Children provide tertiary and quaternary pediatric services, including bone marrow and kidney transplants, as well as burn services. A number of our hospitals also offer advanced treatment options for patients — Good Samaritan Medical Center, North Shore Medical Center, Sierra Medical Center and Sierra Providence East Medical Center offer gamma-knife brain surgery; and Brookwood Medical Center, North Shore Medical Center, Saint Vincent Hospital at Worcester Medical Center and St. Louis University Hospital offer cyberknife radiation therapy for tumors and lesions in the brain, lung, neck, spine and elsewhere that may previously have been considered inoperable or inaccessible by traditional radiation therapy. In addition, our hospitals will continue their efforts to develop and deliver those outpatient services that can be provided on a quality, cost-effective basis and that we believe will meet the needs of the communities served by the facilities.

Many of our hospitals also offer a wide range of clinical research studies, giving patients access to innovative care. We are dedicated to helping our hospitals participate in medical research that is consistent with state and federal regulations and provides good clinical practice guidelines. Clinical research programs relate to a wide array of ailments, including cardiovascular disease, pulmonary disease, musculoskeletal disorders, neurological disorders, genitourinary disease and various cancers, as well as medical device studies. By supporting clinical research, our hospitals are actively involved in medical advancements that can lead to improvements in patient safety and clinical care.

Except as set forth in the table below, each of our acute care hospitals is accredited by The Joint Commission (formerly, The Joint Commission on Accreditation of Healthcare Organizations). With such accreditation, our hospitals are

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deemed to meet the Medicare Conditions of Participation and are eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs.

The following table lists, by state, the hospitals owned or leased and operated by our subsidiaries as of December 31, 2013:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	631	Owned
Arizona			
Arizona Heart Hospital(1)	Phoenix	59	Owned
Arrowhead Hospital	Glendale	217	Owned
Maryvale Hospital	Phoenix	232	Owned
Paradise Valley Hospital	Phoenix	136	Owned
Phoenix Baptist Hospital	Phoenix	221	Owned
West Valley Hospital	Goodyear	164	Owned
California			
Desert Regional Medical Center(2)	Palm Springs	387	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
John F. Kennedy Memorial Hospital	Indio	156	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center(3)	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
North Shore Medical Center — FMC Campus	Lauderdale Lakes	459	Owned
Palm Beach Gardens Medical Center(4)	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
Saint Mary's Medical Center	West Palm Beach	464	Owned
West Boca Medical Center	Boca Raton	195	Owned
Georgia			
Atlanta Medical Center	Atlanta	762	Owned
Atlanta Medical Center — South Campus(5)	East Point	—	Owned
North Fulton Regional Hospital(6)	Roswell	202	Leased
Spalding Regional Hospital	Griffin	160	Owned
Sylvan Grove Hospital(7)	Jackson	25	Leased
Illinois			
Louis A. Weiss Memorial Hospital	Chicago	236	Owned
MacNeal Hospital	Berwyn	373	Owned
West Suburban Medical Center	Oak Park	234	Owned
Westlake Hospital(8)	Melrose Park	242	Owned
Massachusetts			
MetroWest Medical Center — Framingham Union Hospital	Framingham	147	Owned
MetroWest Medical Center — Leonard Morse Hospital	Natick	122	Owned
Saint Vincent Hospital at Worcester Medical Center	Worcester	321	Owned

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Hospital	Location	Licensed Beds	Status
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	298	Owned
Harper University Hospital	Detroit	567	Owned
Huron Valley-Sinai Hospital	Commerce Township	153	Owned
Hutzel Women's Hospital(9)	Detroit	—	Owned
Rehabilitation Institute of Michigan(1)	Detroit	94	Owned
Sinai-Grace Hospital	Detroit	404	Owned
DMC Surgery Hospital(1)	Madison Heights	67	Owned
Missouri			
Des Peres Hospital	St. Louis	143	Owned
St. Louis University Hospital	St. Louis	356	Owned
North Carolina			
Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center(10)	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher's Hospital for Children	Philadelphia	189	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital — Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake	Dallas	218	Owned
Houston Northwest Medical Center(11)	Houston	430	Owned
Lake Pointe Medical Center(12)	Rowlett	112	Owned
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
North Central Baptist Hospital	San Antonio	340	Owned
Northeast Baptist Hospital	San Antonio	379	Owned
Park Plaza Hospital	Houston	444	Owned
Providence Memorial Hospital	El Paso	508	Owned
Sierra Medical Center	El Paso	349	Owned
Sierra Providence East Medical Center	El Paso	110	Owned
St. Luke's Baptist Hospital	San Antonio	282	Owned
Valley Baptist Medical Center — Brownsville(13)	Brownsville	280	Owned
Valley Baptist Medical Center(13)	Harlingen	586	Owned
Total Licensed Beds		**20,293**	

(1) Specialty hospital.
(2) Lease expires in 2027.
(3) Owned by a limited liability company formed as part of a joint venture with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other health care services in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2013 and is the managing member, and John Muir Health owned a 49% interest.
(4) Lease expires in February 2017, but may be renewed through at least February 2037, subject to certain conditions contained in the lease.
(5) Licensed beds for Atlanta Medical Center — South Campus are presented on a combined basis with Atlanta Medical Center.
(6) Lease expires in February 2020, but may be renewed through at least February 2040, subject to certain conditions contained in the lease.

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(7) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation. The current lease term for this facility expires in December 2016, but may be renewed through December 2046, subject to certain conditions contained in the lease.
(8) Accredited by the American Osteopathic Association.
(9) Licensed beds for Hutzel Women's Hospital are presented on a combined basis with Harper University Hospital.
(10) Lease expires in February 2022, but may be renewed through at least February 2042, subject to certain conditions contained in the lease.
(11) Owned by a limited liability company in which a Tenet subsidiary owned an 86.69% interest at December 31, 2013 and is the managing member.
(12) Owned by a limited liability company in which a Tenet subsidiary owned a 94.674% interest at December 31, 2013 and is the managing member.
(13) Indirectly owned by a limited liability company formed as part of a joint venture with VB Medical Holdings (formerly known as Valley Baptist Medical Center — Brownsville), a Texas non-profit corporation; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2013 and is the managing member, and VB Medical Holdings owned a 49% interest.

The following table presents the number of hospitals operated by our subsidiaries, as well as the total number of licensed beds at those facilities, at December 31, 2013, 2012 and 2011:

	December 31,		
	2013	2012	2011
Total number of facilities(1)	77	49	50
Total number of licensed beds(2)	20,293	13,216	13,453

(1) Includes all general and specialty hospitals and our critical access hospital, as well as one facility at December 31, 2011 that is classified in discontinued operations for financial reporting purposes as of December 31, 2013 and 2012.
(2) Information regarding utilization of licensed beds and other operating statistics can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

As of December 31, 2013, we also owned 183 free-standing and provider-based outpatient centers in 16 states — typically at locations complementary to our hospitals — including diagnostic imaging centers, ambulatory surgery centers, urgent care centers and satellite emergency departments, among others. Most of these outpatient centers are in leased facilities, and a number of outpatient facilities are owned and operated by joint ventures in which we hold a majority equity interest. The largest concentrations of our outpatient centers were in those states where we had the largest concentrations of licensed hospital beds, as of December 31, 2013, as shown in the table below:

	% of Outpatient Centers	% of Licensed Beds
Texas	31.7%	25.7%
Florida	16.4%	17.1%
California	16.4%	11.5%

Strong concentrations of hospital beds and outpatient centers within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Health Plans and Accountable Care Networks—During the year ended December 31, 2013, we acquired five health plans with approximately 140,000 members through our acquisition of Vanguard:

- VHS Phoenix Health Plan, LLC, a Medicaid-managed health plan operating as Phoenix Health Plan ("PHP") in Arizona;
- Phoenix Health Plans, Inc. (formerly known as Abrazo Advantage Health Plan, Inc.), a Medicare and Medicaid dual-eligible managed health plan operating in Arizona;
- Chicago Health System, Inc. ("CHS"), a contracting entity for inpatient and outpatient services provided by MacNeal Hospital, Louis A.Weiss Memorial Hospital and participating physicians in the Chicago area;
- Harbor Health Plan, Inc. (formerly known as ProCare Health Plan, Inc.), a Medicaid-managed health plan operating in Michigan; and
- Valley Baptist Insurance Company ("VBIC"), which is currently in the process of changing its name to Allegian Health Plan, offers health maintenance organization ("HMO"), preferred provider organization ("PPO"), and self-funded products to its members in the form of large group, small group and individual product offerings in south Texas. As of January 1, 2014, VBIC also offers a Medicare Advantage health plan.

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We also own Golden State Medicare Health Plan, which is an HMO that specializes in the care of seniors in Southern California who are eligible for benefits under the Medicare Advantage program.

We believe these health plans complement and enhance our market position and provide us with expertise that we expect will be increasingly important as the health care industry evolves. Specifically, PHP provides us with insights into state initiatives to manage the Arizona Medicaid population, which is valuable in light of the expansion of health coverage to currently uninsured patients pursuant to the Affordable Care Act and various other health care reform laws. In addition, through CHS, our Chicago-based preferred provider network, we manage capitated contracts covering inpatient, outpatient and physician services. We believe our ownership of CHS allows us to gain additional experience with risk-bearing contracts and delivery of care in low-cost settings, including our network of health centers.

We also own or control six accountable care networks — in Florida, California, Illinois, Michigan and Texas — and participate in two additional accountable care networks through collaborations with other health care providers in our markets in Arizona and Massachusetts. These networks operate using a range of payment and delivery models that seek to align provider reimbursement in a way that encourages improved quality metrics and efficiencies in the total cost of care for an assigned population of patients through cooperation of the providers. We believe that our experience operating health plans and accountable care networks gives us a solid framework upon which to build and expand our population health strategies.

CONIFER

Our Conifer subsidiary provides a number of services primarily to health care providers to assist them in generating sustainable improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. At December 31, 2013, Conifer provided one or more of the business process services described below from 20 service centers to more than 700 Tenet and non-Tenet hospital and other clients in over 40 states.

Revenue Cycle Management—Conifer provides comprehensive operational management for patient access, health information management, revenue integrity and patient financial services, including:

- centralized insurance and benefit verification, financial clearance, pre-certification, registration and check-in services;
- financial counseling services, including reviews of eligibility for government health care programs, for both insured and uninsured patients;
- productivity and quality improvement programs, revenue cycle assessments and optimization recommendations, and The Joint Commission and other preparedness services;
- coding and compliance support, billing assistance, auditing, training, and data management services at every step in the revenue cycle process;
- accounts receivable management, third-party billing and collections; and
- ongoing measurement and monitoring of key revenue cycle metrics.

These revenue cycle management solutions assist hospitals and other health care organizations in improving cash flow, increasing revenue, and advancing physician and patient satisfaction.

Patient Communications and Engagement Services—Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referrals, calls regarding maternity services and other patient inquiries, (2) community education and outreach, (3) scheduling and appointment reminders, and (4) employee recruitment. Conifer also coordinates and implements mail-based marketing programs to keep patients informed of screenings, seminars and other events and services, as well as conducts patient quality and satisfaction surveys to provide valuable feedback to its clients. In addition, Conifer provides clinical admission reviews that are intended to provide evidence-based support for physician decisions on patient status and reduce staffing costs.

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Management Services—Conifer also supports value-based performance through clinical integration, financial risk management and population health management, all of which assist hospitals, physicians, accountable care organizations ("ACOs"), health plans and employers in improving the cost and quality of health care delivery, as well as patient outcomes. Conifer helps clients build clinically integrated networks that provide predictive analytics and quality measures across the care continuum. In addition, Conifer assists clients in improving both the cost and quality of care by aligning and managing financial incentives among health care stakeholders through risk modeling and management for various payment models. Furthermore, Conifer offers clients tools and analytics to improve quality of care and provide care management support of patients with chronic diseases by identifying high-risk patients and monitoring clinical outcomes.

In May 2012, Conifer entered into a 10-year agreement with Catholic Health Initiatives ("CHI") to provide revenue cycle services for over 50 of CHI's hospitals. As part of this agreement, CHI received a minority ownership interest in Conifer. In addition, in late 2012, Conifer acquired (i) an information management and services company with extensive health care data and proprietary technology and (ii) a hospital revenue cycle management business.

We began reporting Conifer as a separate business segment for financial reporting purposes in the three months ended June 30, 2012. The loss of Conifer's key customers, primarily Tenet and CHI, in the future could have a material adverse impact on the segment. Financial and other information about our Conifer business segment is provided in the Consolidated Financial Statements included in this report.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2013 are set forth in the table beginning on page 3. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own nearly all of our medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

Our corporate headquarters are located in Dallas, Texas. In addition, we maintain administrative and regional offices in markets where we operate hospitals and other businesses, including Conifer. We typically lease our office space under operating lease agreements. We believe that all of our properties are suitable for their respective uses and are, in general, adequate for our present needs.

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. In addition, Conifer has sought patent protection for one of its key innovations. Legal standards relating to the validity, enforceability and scope of protection of patents can be uncertain. We do not know whether Conifer's patent application will result in the issuance of a patent or whether the examination process will require us to further narrow our claims. Our patent application may not result in the grant of a patent with the scope of the claims that we seek, if at all, or the scope of the granted claims may not be sufficiently broad to protect our technology. Any patents that may be granted in the future from pending or future applications may be opposed, contested, circumvented, designed around by a third party, or found to be invalid or unenforceable. Third parties may develop technologies that are similar or superior to our proprietary technologies, duplicate or otherwise obtain and use our proprietary technologies, or design around patents owned or licensed by us. Conversely, although we do not believe our technology infringes any patent or other intellectual property right held by a third party, we could be prevented from providing our service offerings and could be subject to significant damage awards if it is found to do so.

We control access to and the use of our application capabilities through a combination of internal and external controls. We also license some of our software through agreements that impose specific restrictions on customers' ability to use the software, such as prohibiting reverse engineering and limiting the use of copies.

We incorporate third-party commercial and, on occasion, open source software products into our technology platform. We employ third-party licensed software in order to simplify our development and maintenance efforts, support our own technology infrastructure or test a new capability.

MEDICAL STAFF AND EMPLOYEES

General—Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations

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subject to ultimate oversight by the hospital's local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of hospitals not owned by us. Members of our medical staffs are free to terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. As of December 31, 2013, we owned over 500 physician practices and employed over 1,500 physicians (where permitted by law). However, the overwhelming majority of the physicians who practice at our hospitals are not our employees. Nurses, therapists, lab technicians, facility maintenance workers and the administrative staffs of hospitals normally are our employees. We are subject to federal minimum wage and hour laws and various state labor laws, and maintain a number of different employee benefit plans.

Our operations depend on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no contractual relationship with us. It is essential to our ongoing business that we attract and retain on our medical staffs an appropriate number of quality physicians in the specialties required to support our services. Although we had a net overall gain in physicians added to the medical staffs of legacy Tenet hospitals in each of the last three years, in some of our markets, physician recruitment and retention are still affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance.

Over 40,000 new employees joined Tenet in October 2013 in connection with our acquisition of Vanguard. As of December 31, 2013, we employed over 100,000 employees (of which 27% were part-time employees) in the following categories:

Hospital operations(1)	92,094
Conifer	10,145
Administrative offices	1,472
Total	103,711

(1) Includes employees whose employment related to the operations of our general hospitals, specialty hospitals, critical access hospital, long-term acute care hospital, outpatient centers, physician practices, health plans, accountable care networks and other health care operations.

Union Activity and Labor Relations—As of December 31, 2013, approximately 21% of our employees were represented by various labor unions. These employees — primarily registered nurses and service and maintenance workers — were located at 39 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating an initial contract at one of our hospitals where employees recently chose union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014.

Shortage of Experienced Nurses and Mandatory Nurse-Staffing Ratios— In addition to union activity, factors that adversely affect our labor costs include the nationwide shortage of experienced nurses and the enactment of state laws regarding nurse-staffing ratios. Although our nurse turnover rates are favorable overall, like others in the health care industry, we continue to experience a shortage of seasoned nurses in certain key specialties and geographic areas. Most applicants for our nursing positions are newly licensed nurses rather than experienced nurses, which requires us to make greater investments in education and training. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. We continually monitor our nurse-staffing ratios in California in an effort to achieve full compliance with the state-mandated nurse-staffing ratios there. Nurse-staffing ratio legislation has been proposed in, but not yet enacted by, Congress and other states besides California in which we operate hospitals, including Florida, Michigan and Pennsylvania. In Texas and Missouri, hospitals are required to adopt, implement and enforce official nurse staffing plans, but are not required to maintain staffing ratios.

COMPETITION

HEALTH CARE SERVICES

Overall, our hospitals, outpatient centers and other health care businesses operate in competitive environments, primarily at the local level. Generally, other hospitals and outpatient centers in the local communities we serve provide services

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similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, competing facilities (1) may offer a broader array of services to patients and physicians than ours, (2) may have larger or more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, or (4) may be more centrally located with better parking or closer proximity to public transportation. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and health care companies in specific geographic markets. Continued consolidation in the health care industry will be a leading factor contributing to greater competition in our current markets and markets we may enter in the future.

We also face increased competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high-margin services and for quality physicians and personnel. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations. These tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. In addition, in certain markets in which we operate, large teaching hospitals provide highly specialized facilities, equipment and services that may not be available at our hospitals.

Another major factor in the competitive position of a hospital or outpatient facility is the ability to negotiate contracts with managed care plans. HMOs, PPOs, third-party administrators, and other third-party payers use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Our future success depends, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care providers may affect our ability to enter into acceptable managed care contractual arrangements or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Furthermore, the trend toward consolidation among non-government payers tends to increase their bargaining power over fee structures. In addition, as various provisions of the Affordable Care Act are implemented, including the establishment of health insurance exchanges, non-government payers may increasingly demand reduced fees or be unwilling to negotiate reimbursement increases.

State laws that require findings of need for construction and expansion of health care facilities or services (as described in "Health Care Regulation and Licensing — Certificate of Need Requirements" below) may also have the effect of restricting competition. In addition, in those states that do not have certificate of need requirements or that do not require review of health care capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

Our strategies are designed to help our hospitals remain competitive. Broadly speaking, we attract physicians by providing high-quality care to our patients and otherwise creating an environment in which physicians prefer to practice. We continue to invest in our *Physician Relationship Program,* which is centered on understanding the needs of physicians who admit patients both to our hospitals and to our competitors' hospitals and responding to those needs with changes and improvements in our hospitals and operations. We have targeted capital spending in order to address specific needs or growth opportunities of our hospitals, which is expected to have a positive impact on their volumes. We have also sought to include all of our hospitals and an increased number of our affiliated physicians in the affected geographic area or nationally when negotiating new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks. In addition, we have completed clinical service line market demand analyses and profitability assessments to determine which services are highly valued that can be emphasized and marketed to improve our operating results. This *Targeted Growth Initiative* ("TGI") has resulted in some reductions in unprofitable service lines in several locations. However, the de-emphasis or elimination of certain unprofitable service lines as a result of our TGI analyses will allow us to dedicate more resources on services that are in higher demand and are more profitable. Moreover, we have increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, as well as increased predictability and efficiency for physicians.

We have also made significant investments in the last decade in equipment, technology, education and operational strategies designed to improve clinical quality at our hospitals and outpatient centers. As a result of our efforts, our CMS Hospital Compare Core Measures scores have consistently exceeded the national average since the end of 2005, and major national private payers have also recognized our achievements relative to quality. These designations are expected to become increasingly important as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others. Through our *Commitment to Quality* and *Performance Excellence Program* initiatives, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using

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labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effect of reducing costs, increasing payments from Medicare and certain managed care payers for our services, and increasing physician and patient satisfaction, which may improve our volumes.

Further, each hospital has a local governing board, consisting primarily of community members and physicians, that develops short-term and long-term plans for the hospital to foster a desirable medical environment. Each local governing board also reviews and approves, as appropriate, actions of the medical staff, including staff appointments, credentialing, peer review and quality assurance. While physicians may terminate their association with our hospitals at any time, we believe that by striving to maintain and improve the quality of care at our hospitals and by maintaining ethical and professional standards, we will attract and retain qualified physicians with a variety of specialties.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Our Conifer subsidiary faces competition from existing participants and new entrants to the revenue cycle management market. In addition, the internal revenue cycle management staff of hospitals and other health care providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions sometimes choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, most of which focus on small components of the hospital revenue cycle, including:

- software vendors and other technology-supported revenue cycle management business process outsourcing companies;
- traditional consultants, either specialized health care consulting firms or health care divisions of large accounting firms; and
- large, non-healthcare focused business process and information technology outsourcing firms.

We believe that competition for the revenue cycle management and other services Conifer provides is based primarily on: (1) knowledge and understanding of the complex public and private health care payment and reimbursement systems; (2) a track record of delivering revenue improvements and efficiency gains for hospitals and other health care providers; (3) the ability to deliver solutions that are fully integrated along each step of the revenue cycle; (4) cost-effectiveness, including the breakdown between up-front costs and pay-for-performance incentive compensation; (5) reliability, simplicity and flexibility of the technology platform; (6) understanding of the health care industry's regulatory environment; (7) sufficient infrastructure; and (8) financial stability.

To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

HEALTH CARE REGULATION AND LICENSING

AFFORDABLE CARE ACT

The Affordable Care Act is changing how health care services in the United States are covered, delivered and reimbursed. The primary goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. To fund the expansion of insurance coverage, the legislation contains measures designed to promote quality and cost efficiency in health care delivery and to generate budgetary savings in the Medicare and Medicaid programs. In addition, the Affordable Care Act contains provisions intended to strengthen fraud and abuse enforcement.

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Health Insurance Market Reforms—The Affordable Care Act contains provisions requiring most Americans to maintain, and employers to provide, "minimal essential" health insurance coverage. For individuals who are not exempt from the "individual mandate," and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Health insurance exchanges are government-regulated organizations that provide competitive markets for buying health insurance by offering individuals and small employers a choice of different health plans, certifying plans that participate, and providing information to help consumers better understand their options. Some states operate their own exchanges while others utilize federally facilitated exchanges. The federally run exchanges, and several of the state-run exchanges, have faced operational hurdles and challenges in the initial period of their operation, which could reduce the number of individuals that obtain coverage through the exchanges in the short term. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Also beginning in 2014, those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty.

The "employer mandate" provision of the Affordable Care Act requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. These large employer coverage provisions were originally scheduled to go into effect on January 1, 2014, but were subsequently deferred one year. On February 10, 2014, the requirements of the employer mandate were further delayed such that companies with 50 to 99 employees will now have until January 1, 2016 to provide coverage under the Affordable Care Act, and companies with 100 or more employees must offer insurance to only 70% of full-time workers in 2015, rather than 95%, to avoid fines. Based on the Congressional Budget Office's most recent estimates, we do not believe that the delays in the employer mandate will have a discernible effect on insurance coverage.

The Affordable Care Act also establishes a number of health insurance market reforms, including bans on lifetime limits and pre-existing condition exclusions, new benefit mandates, and increased dependent coverage. Specifically, group health plans and health insurance issuers offering group or individual coverage:

- may not establish lifetime limits or, beginning January 1, 2014, annual limits on the dollar value of benefits;
- may not rescind coverage of an enrollee, except in instances where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact;
- must reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place; and
- must continue to make dependent coverage available to unmarried dependents until age 26 (coverage for the dependents of unmarried adult children is not required) effective for health plan policy years beginning on or after September 23, 2010 (for plans that offer dependent coverage).

We anticipate that health care providers will generally benefit over time from insurance coverage provisions of the Affordable Care Act; however, it is not clear what impact, if any, the increased obligations on managed care and other private payers imposed by the Affordable Care Act will have on commercial managed care volumes and payment rates in the near term.

Public Program Reforms—Prior to the passage of the Affordable Care Act, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The health care reform law expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. The expansion of the Medicaid program (which will be substantially funded by the federal government) in each state requires state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. There is no deadline for a state to undertake expansion and qualify for the enhanced federal funding available under the Affordable Care Act. We cannot provide any assurances as to whether or when the states in which we operate might choose to expand their Medicaid programs or whether those states that do expand their Medicaid programs will continue to offer expanded eligibility in the future.

The Affordable Care Act also provides that the federal government will subsidize states that create non-Medicaid plans called "Basic Health Programs" for residents whose incomes are greater than 133% but less than 200% of the federal poverty level. Approved state plans will be eligible to receive federal funding, however, CMS announced in February 2013 that Basic Health Programs would not be operational until 2015.

Even though the Affordable Care Act expanded Medicaid eligibility, the law also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including:

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- negative adjustments to the annual input price index, or "market basket," updates for Medicare's inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and

- reductions to Medicare disproportionate share hospital ("DSH") payments, beginning in federal fiscal year ("FFY") 2014, as the number of uninsured individuals declines. Medicaid DSH cuts were also initially scheduled to begin in FFY 2014, however, a provision in the Bipartisan Budget Act of 2013 delayed these cuts until FFY 2016.

The Affordable Care Act also contains a number of provisions intended to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. For example, the legislation expands payment penalties based on a hospital's rates of certain Medicare-designated hospital-acquired conditions ("HACs"). These HACs, which would normally result in a higher payment for an inpatient hospital discharge, will instead be paid as though the HAC is not present. Effective July 1, 2011, the Affordable Care Act likewise prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Currently, hospitals with excessive readmissions for certain conditions receive reduced Medicare payments for all inpatient admissions. Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will also receive a 1% reduction in Medicare payment rates. Separately, under a Medicare value-based purchasing program that was launched in FFY 2013, hospitals that satisfy certain performance standards receive increased payments for discharges during the following fiscal year. These payments are funded by decreases in payments to all hospitals for inpatient services. For discharges occurring during FFY 2014 and after, the performance standards must assess hospital efficiency, including Medicare spending per beneficiary. In addition, the Affordable Care Act directed CMS to launch a national pilot program to study the use of bundled payments to hospitals, physicians and post-acute care providers relating to a single admission to promote collaboration and alignment on quality and efficiency improvement; implementation of the pilot program is currently ongoing through the Center for Medicare and Medicaid Innovation within CMS, which has the authority to develop and test new payment methodologies designed to improve quality of care and lower costs.

Furthermore, the Affordable Care Act contains provisions relating to recovery audit contractors ("RACs"), which are third-party organizations under contract with CMS that identify underpayments and overpayments under the Medicare program and recoup any overpayments on behalf of the government. The Affordable Care Act expanded the RAC program's scope to include Medicaid claims and required all states to enter into contracts with RACs.

Other Provisions—The Affordable Care Act contains a number of other additional provisions, including provisions relating to the Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments, Section 1877 of the Social Security Act (commonly referred to as the "Stark" law), and qui tam or "whistleblower" actions, each of which is described in detail below, as well as provisions regarding:

- the creation of an Independent Payment Advisory Board that will make recommendations to Congress regarding additional changes to provider payments and other aspects of the nation's health care system; and

- new taxes on manufacturers and distributors of pharmaceuticals and medical devices used by our hospitals, as well as a requirement that manufacturers file annual reports of payments made to physicians.

The Impact of Health Reform on Us—The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either private or public program coverage. Further, the health reform law provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue. However, it is difficult to predict the full impact of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding a number of material factors, including:

- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);

- how many currently uninsured individuals will obtain coverage (either private health insurance or Medicaid) as a result of the Affordable Care Act;

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- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that the Affordable Care Act or components of it will be delayed, revised or eliminated as a result of court challenges or actions by Congress.

Furthermore, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. Any reductions to our reimbursement under the Medicare and Medicaid programs by the Affordable Care Act could adversely affect our business and results of operations to the extent such reductions are not offset by increased revenues from providing care to previously uninsured individuals. It is difficult to predict the effect on our revenues resulting from reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are implemented;
- whether future reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the size of the law's annual productivity adjustment to the market basket;
- the amount of the Medicare DSH reductions that will be made commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions commencing in FFY 2016;
- what the losses in revenues, if any, will be from the law's quality initiatives;
- how successful accountable care networks in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

In addition, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government health care program.

Because of the many variables involved, we are unable to predict the ultimate net effect on us of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and Medicare and Medicaid DSH funding, and

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numerous other provisions in the Affordable Care Act that may affect us. Moreover, we are unable to predict the future course of federal, state and local health care regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Anti-Kickback Statute—Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute") prohibit certain business practices and relationships that might affect the provision and cost of health care services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal health care programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program. Moreover, the Affordable Care Act amended the Anti-kickback Statute to provide that knowledge of the law or the intent to violate the law is not required.

Sanctions for violating the Anti-kickback Statute include criminal and civil penalties, as well as fines and possible exclusion from government programs, such as Medicare and Medicaid. In addition, under the Affordable Care Act, submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act ("FCA"). Furthermore, it is a violation of the federal Civil Monetary Penalties Law to offer or transfer anything of value to Medicare or Medicaid beneficiaries that is likely to influence their decision to obtain covered goods or services from one provider or service over another. Many states have statutes similar to the federal Anti-kickback Statute, except that the state statutes usually apply to referrals for services reimbursed by all third-party payers, not just federal programs.

The federal government has also issued regulations that describe some of the conduct and business relationships that are permissible under the Anti-kickback Statute. These regulations are often referred to as the "Safe Harbor" regulations. Currently, there are safe harbors for various activities, including the following: investment interests; space rental; equipment rental; practitioner recruitment; personal services and management contracts; sales of practices; referral services; warranties; discounts; employees; group purchasing organizations; waivers of beneficiary coinsurance and deductible amounts; managed care arrangements; obstetrical malpractice insurance subsidies; investments in group practices; ambulatory surgery centers; and referral agreements for specialty services. The fact that certain conduct or a given business arrangement does not meet a Safe Harbor does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. Rather, such conduct and business arrangements may be subject to increased scrutiny by government enforcement authorities and should be reviewed on a case-by-case basis.

Stark Law—The Stark law generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined "designated health services," such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services. The exceptions to the referral prohibition cover a broad range of common financial relationships. These statutory, and the subsequent regulatory, exceptions are available to protect certain permitted employment relationships, relocation arrangements, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark Law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

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The Affordable Care Act also made changes to the "whole hospital" exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in existing physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital has physician ownership and a Medicare provider agreement as of March 23, 2010 (or, for those hospitals under development at the time of the Affordable Care Act's enactment, as of December 31, 2010). A physician-owned hospital that meets these requirements will still be subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for hospitals with a high percentage of Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. The legislation also subjects a physician-owned hospital to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements. As of December 31, 2013, two of our hospitals are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals.

Implications of Fraud and Abuse Laws—Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

We have a variety of financial relationships with physicians who refer patients to our hospitals, and we may sell ownership interests in certain of our other facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

In accordance with our ethics and compliance program, which is described in detail under "Compliance and Ethics" below, we have policies and procedures in place concerning compliance with the Anti-kickback Statute and the Stark law, among others. In addition, our ethics and compliance, law and audit services departments systematically review a substantial number of our arrangements with referral sources to determine the extent to which they comply with our policies and procedures and with the Anti-kickback Statute, the Stark law and similar state statutes. On the one hand, we may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors and exceptions to the fraud and abuse laws described above; as a result, this unwillingness may put us at a competitive disadvantage. On the other hand, we cannot assure you that the regulatory authorities that enforce these laws will not determine that some of our arrangements violate the Anti-Kickback Statute, the Stark law or other applicable regulations. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that we have violated any of these laws could give Conifer's customers the right to terminate our services agreements with them. Moreover, any violations by and resulting penalties or exclusions imposed upon Conifer's customers could adversely affect their financial condition and, in turn, have a material adverse effect on Conifer's business and results of operations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Title II, Subtitle F of the Health Insurance Portability and Accountability Act mandates the adoption of specific standards for electronic transactions and code sets that are used to transmit certain types of health information. HIPAA's objective is to encourage efficiency and reduce the cost of operations within the health care industry. To protect the information transmitted using the mandated standards and the patient information used in the daily operations of a covered entity, HIPAA also sets forth federal rules protecting the privacy and security of protected health information ("PHI"). The privacy and security regulations address the use and disclosure of individually identifiable health information and the rights of patients to understand and control how their information is used and disclosed. The law provides both criminal and civil fines and penalties for covered entities that fail to comply with HIPAA.

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To receive reimbursement from CMS for electronic claims, health care providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain health care information electronically. Our electronic data transmissions are compliant with current standards. In January 2009, CMS published a final rule changing the formats used for certain electronic transactions and requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. At this time, use of the ICD-10 code sets is not mandatory until October 1, 2014. We are continuing to modify our payment systems and processes to prepare for ICD-10 implementation. Although use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial condition, results of operations or revenues. However, we may experience a short-term adverse impact on our cash flows due to claims processing delays related to payer implementation of the new code sets. Furthermore, the Affordable Care Act requires the U.S. Department of Health and Human Services ("HHS") to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

Under HIPAA, covered entities must establish administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic PHI maintained or transmitted by them or by others on their behalf. The covered entities we operate are in material compliance with the privacy, security and National Provider Identifier requirements of HIPAA. In addition, most of Conifer's customers are covered entities, and Conifer is a business associate to many of those customers under HIPAA as a result of its contractual obligations to perform certain functions on behalf of and provide certain services to those customers. As a business associate, Conifer's use and disclosure of PHI is restricted by HIPAA and the business associate agreements Conifer is required to enter into with its covered entity customers.

In 2009, HIPAA was amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act to impose certain of the HIPAA privacy and security requirements directly upon business associates of covered entities and significantly increase the monetary penalties for violations of HIPAA. Regulations that took effect in late 2009 also require business associates such as Conifer to notify covered entities, who in turn must notify affected individuals and government authorities, of data security breaches involving unsecured PHI. Since the passage of the HITECH Act, enforcement of HIPAA violations has increased. A knowing breach of the HIPAA privacy and security requirements made applicable to business associates by the HITECH Act could expose Conifer to criminal liability, and a breach of safeguards and processes that is not due to reasonable cause or involves willful neglect could expose Conifer to significant civil penalties and the possibility of civil litigation under HIPAA and applicable state law.

In May 2011, the Office for Civil Rights of HHS proposed new regulations to implement changes to the HIPAA requirements set forth in the HITECH Act that state that covered entities and business associates must account for disclosures of PHI to carry out treatment, payment and health care operations if such disclosures are through an electronic health record. The proposed regulations seek to expand the scope of the requirements under the HITECH Act and create a new patient right to an "access report," which would be required to list every person who has accessed, for any reason, PHI about the individual contained in any electronic designated record set. Because our hospitals currently utilize multiple, independent modules that may meet the definition of "electronic designated record set," our ability to produce an access report that satisfies the proposed regulatory requirements would likely require new technology solutions to map across those multiple record sets. It is our understanding that many providers have expressed significant concerns to CMS regarding the access report requirement created by the proposed rule. On January 17, 2013, HHS issued final regulations modifying the requirements set forth in the HITECH Act. While we were in material compliance with the new regulations as of the compliance date of September 23, 2013, the new regulations did not address the proposed "access report" requirement. Because we cannot predict the requirements of any future final rule regarding access reports, we are unable to estimate the costs of compliance, if any, at this time.

We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA, and similar state privacy laws, under the guidance of our ethics and compliance department. Hospital and Conifer compliance officers and information security officers are responsible for implementing and monitoring compliance with our HIPAA privacy and security policies and procedures at our hospitals and Conifer. We have also created an internal web-based HIPAA training program, which is mandatory for all employees. Based on existing regulations and our experience with HIPAA to this point, we continue to believe that the ongoing costs of complying with HIPAA will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

HEALTH PLAN REGULATORY MATTERS

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our Medicare Advantage and dual-eligible health plans to determine the plans' compliance with CMS regulations and guidelines. In addition, each plan must submit periodic filings to and respond to inquiries and audits by its respective state insurance regulators.

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Furthermore, our health plans are typically required to file periodic reports with their respective state Medicaid agencies, meet certain financial viability standards, provide their members with certain mandated benefits, and meet certain quality assurance and improvement requirements. Our health plans must also comply with the standardized formats for electronic transmissions and the privacy and security standards of HIPAA. We believe our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

As described above, the Anti-kickback Statute prohibits the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal health care program. The Safe Harbor regulations that specifically relate to managed care include:

- waivers by HMOs of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care providers.

We believe that our health plans' arrangements comply in all material respects with the federal Anti-kickback Statute and similar state statutes, and we further believe that the incentives offered by our health plans to their members and the discounts they receive contracting with health care providers satisfy the requirements of the Safe Harbor regulations.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the health care industry. The operational mission of the Office of Inspector General ("OIG") of HHS is to protect the integrity of the Medicare and Medicaid programs and the well-being of program beneficiaries by: detecting and preventing waste, fraud and abuse; identifying opportunities to improve program economy, efficiency and effectiveness; and holding accountable those who do not meet program requirements or who violate federal laws. The OIG carries out its mission by conducting audits, evaluations and investigations and, when appropriate, imposing civil monetary penalties, assessments and administrative sanctions. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with the laws, rules and regulations affecting the health care industry, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition, results of operations or cash flows could be materially adversely affected.

Health care providers are also subject to qui tam or "whistleblower" lawsuits under the federal False Claims Act, which allows private individuals to bring actions on behalf of the government, alleging that a hospital or health care provider has defrauded a government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Affordable Care Act, the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, constitutes a violation of the FCA. Further, the Affordable Care Act expands the scope of the FCA to cover payments in connection with health insurance exchanges if those payments include any federal funds. Qui tam actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies. Like other companies in the health care industry, we are subject to qui tam actions from time to time. We are unable to predict the future impact of such actions on our business, financial condition, results of operations or cash flows.

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HEALTH CARE FACILITY LICENSING REQUIREMENTS

The operation of health care facilities is subject to federal, state and local regulations relating to personnel, operating policies and procedures, fire prevention, rate-setting, the adequacy of medical care, and compliance with building codes and environmental protection laws. Various licenses and permits also are required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our health care facilities hold all required governmental approvals, licenses and permits material to the operation of their business.

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

In addition to certain statutory coverage limits and exclusions, federal laws and regulations, specifically the Medicare Conditions of Participation, generally require health care providers, including hospitals that furnish or order health care services that may be paid for under the Medicare program or state health care programs, to ensure that claims for reimbursement are for services or items that are (1) provided economically and only when, and to the extent, they are medically reasonable and necessary, (2) of a quality that meets professionally recognized standards of health care, and (3) supported by appropriate evidence of medical necessity and quality. The Social Security Act established the Utilization and Quality Control Peer Review Organization program, now known as the Quality Improvement Organization ("QIO") program, to promote the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. CMS administers the program through a network of QIOs that work with consumers, physicians, hospitals and other caregivers to refine care delivery systems to ensure patients receive the appropriate care at the appropriate time, particularly among underserved populations. The QIO program also safeguards the integrity of the Medicare trust fund by reviewing Medicare patient admissions, treatments and discharges, and ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care. The QIOs have the authority to deny payment for services provided and recommend to HHS that a provider that is in substantial noncompliance with certain standards be excluded from participating in the Medicare program.

There has been recent increased scrutiny of hospitals' Medicare observation rates from outside auditors, government enforcement agencies and industry observers. The term "Medicare observation rate" is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In our affiliated hospitals, we use the independent, evidence-based clinical criteria developed by McKesson Corporation, commonly known as InterQual Criteria, to determine whether a patient qualifies for inpatient admission. The industry anticipates increased scrutiny and litigation risk, including government investigations and qui tam suits, related to inpatient admission decisions and the Medicare observation rate. In addition, effective October 1, 2013, CMS established a new concept, referred to as the "two-midnight rule," to guide practitioners admitting patients and contractors conducting payment reviews on when it is appropriate to admit individuals as hospital inpatients. Under the two-midnight rule, CMS has indicated that a Medicare patient should generally be admitted on an inpatient basis only when there is a reasonable expectation that the patient's care will cross two midnights, and, if not, then the patient generally should be treated as an outpatient. Our hospitals have undertaken extensive efforts to implement the two-midnight rule in light of existing guidance. CMS is currently conducting a "probe and educate" program regarding the two-midnight rule, the purpose of which is to assess hospitals' compliance with the rule and also to provide follow-up education. The probe and educate period is currently scheduled to end September 30, 2014 and, unless extended, full implementation and enforcement of the two-midnight rule will begin on October 1, 2014. Because of the newness of the two-midnight rule, and the fact that the probe and educate program is ongoing, it is unclear what impact, if any, the two-midnight rule will have on inpatient admission rates at our hospitals.

Medical and surgical services and practices are extensively supervised by committees of staff doctors at each of our health care facilities, are overseen by each facility's local governing board, the members of which primarily are community members and physicians, and are reviewed by our clinical quality personnel. The local hospital governing board also helps maintain standards for quality care, develop short-term and long-range plans, and establish, review and enforce practices and procedures, as well as approves the credentials, disciplining and, if necessary, the termination of privileges of medical staff members.

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of health care facilities, including findings of need for additional or expanded health care facilities or services. Certificates or determinations of need, which are issued by

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governmental agencies with jurisdiction over health care facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. As of December 31, 2013, we operated hospitals in 10 states that require a form of state approval under certificate of need programs applicable to those hospitals. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license. We are unable to predict whether we will be required or able to obtain any additional certificates of need in any jurisdiction where they are required, or if any jurisdiction will eliminate or alter its certificate of need requirements in a manner that will increase competition and, thereby, affect our competitive position. In those states that do not have certificate of need requirements or that do not require review of health care capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

ENVIRONMENTAL MATTERS

Our health care operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with laws and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws and regulations, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows.

Consistent with our commitment to meet the highest standards of corporate responsibility, we have formed a sustainability committee consisting of corporate and hospital leaders to regularly evaluate our environmental outcomes and share best practices among our hospitals and other facilities. In 2013, we published our third annual sustainability report, using the industry-standard Global Reporting Initiative framework. In addition, we are a sponsor of the *Healthier Hospitals Initiative* and continue to work with each of our hospitals in adopting components of the initiative's agenda, which focuses on improvements in (1) sustainability governance, (2) the provision of healthier foods, (3) energy consumption, (4) waste generation, (5) the use of safer chemicals and (6) purchasing decisions. We are committed to report the results of our sustainability efforts on an annual basis.

ANTITRUST LAWS

The federal government and most states have enacted antitrust laws that prohibit specific types of anti-competitive conduct, including price fixing, wage fixing, concerted refusals to deal, price discrimination and tying arrangements, as well as monopolization and acquisitions of competitors that have, or may have, a substantial adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties.

Antitrust enforcement in the health care industry is currently a priority of the U.S. Federal Trade Commission ("FTC"). In recent years, the FTC has filed multiple administrative complaints challenging hospital transactions in several states. The FTC has focused its enforcement efforts on preventing hospital mergers that may, in the government's view, leave insufficient local options for inpatient services. In addition to hospital merger enforcement, the FTC has given increased attention to the effect of combinations involving other health care providers, including physician practices. The FTC has also entered into numerous consent decrees in the past several years settling allegations of price-fixing among providers.

We believe we are in compliance with federal and state antitrust laws, but there can be no assurance that a review of our practices by courts or regulatory authorities would not result in a determination that could adversely affect our operations.

REGULATIONS AFFECTING CONIFER

DEBT COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act ("FDCPA") regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable

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handled by Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC ("SOS"), are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. Further, the FDCPA prohibits harassment or abuse by debt collectors, including the threat of violence or criminal prosecution, obscene language or repeated telephone calls made with the intent to abuse or harass. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt and sets forth specific procedures to be followed when communicating with such third parties for purposes of obtaining location information about the consumer. In addition, the FDCPA contains various notice and disclosure requirements and prohibits unfair or misleading representations by debt collectors. Finally, the FDCPA imposes certain limitations on lawsuits to collect debts against consumers. Debt collection activities are also regulated at the state level. Most states have laws regulating debt collection activities in ways that are similar to, and in some cases more stringent than, the FDCPA.

In certain situations, the activities of SOS are also subject to the Fair Credit Reporting Act ("FCRA"), which regulates consumer credit reporting and which may impose liability on us to the extent that adverse credit information reported on a consumer to a credit bureau is false or inaccurate. State law, to the extent it is not preempted by the FCRA, may also impose restrictions or liability on us with respect to reporting adverse credit information that is false or inaccurate.

The U.S. Consumer Financial Protection Bureau ("CFPB") and the FTC have the authority to investigate consumer complaints relating to the FDCPA and the FCRA, and to initiate enforcement actions, including actions to seek restitution and monetary penalties. State officials typically have authority to enforce corresponding state laws. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

The CFPB was formed within the U.S. Federal Reserve pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. In 2013, the CFPB issued examination procedures for, and began conducting examinations of, a number of companies with respect to their debt collection practices. The CFPB's examination authority permits agency examiners to inspect the books and records of companies engaged in debt collection activities, such as SOS, and ask questions about their payment processing activities, collections, accounts in default, consumer reporting and third-party relationships, as well as compliance programs. We believe that the potential exists that non-bank providers of consumer credit that are examined by the CFPB could, depending upon the circumstances, be required, as a result of any CFPB examination, to change their practices or procedures. In August 2013, Conifer received a civil investigative demand from the CFPB that requires Conifer to provide to the CFPB a broad range of information regarding its debt collection activities, including its internal compliance procedures. To date, the CFPB has not indicated that it has targeted any particular issue or concern underlying the issuance of the civil investigative demand. Conifer is cooperating with the CFPB in providing the requested information.

CREDIT CARD ACTIVITIES

Conifer accepts credit card payments from patients of its facilities. Various federal and state laws and regulations impose privacy and information security standards with respect to the acceptance of credit cards as a form of payment. If Conifer fails to comply with these laws and regulations or experiences a credit card security breach, its reputation could be damaged, possibly resulting in lost business, and it could be subjected to additional legal or financial risk as a result of non-compliance.

COMPLIANCE AND ETHICS

General—Our ethics and compliance department maintains our multi-faceted, values-based ethics and compliance program, which is designed to (1) help staff in our corporate and Conifer offices, hospitals, outpatient centers, health plan offices and physician practices meet or exceed applicable standards established by federal and state laws and regulations, as well as industry practice, and (2) monitor and raise awareness of ethical issues among employees and others, and stress the importance of understanding and complying with our *Standards of Conduct*. The ethics and compliance department operates with independence — it has its own operating budget; it has the authority to hire outside counsel, access any Tenet document and interview any of our personnel; and our chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

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Program Charter—In September 2011, the quality, compliance and ethics committee of our board of directors approved an updated Q *uality, Compliance and Ethics Program Charter* intended to:

- support and maintain our present and future responsibilities with regard to participation in federal health care programs; and
- further our goals of (1) fostering and maintaining the highest ethical standards among all employees, officers and directors, physicians practicing at Tenet facilities and contractors that furnish health care items or services, and (2) valuing our compliance with all state and federal laws and regulations as a foundation of our corporate philosophy.

The primary focus of our quality, compliance and ethics program is compliance with the requirements of Medicare, Medicaid and other federally funded health care programs. Pursuant to the terms of the charter, our ethics and compliance department is responsible for the following activities: (1) annually assessing, critiquing and (as appropriate) drafting and distributing company policies and procedures; (2) developing, providing and tracking ethics training for all employees, directors and, as applicable, contractors and agents; (3) developing, providing and tracking job-specific training to those who work in clinical quality, coding, billing, cost reporting and referral source arrangements; (4) developing, providing and tracking annual training on ethics and clinical quality oversight to the members of each hospital governing board; (5) creating and disseminating the company's *Standards of Conduct* and obtaining certifications of adherence to the *Standards of Conduct* as a condition of employment; (6) maintaining and promoting Tenet's Ethics Action Line, which allows confidential reporting of issues on an anonymous basis and emphasizes Tenet's no retaliation policy; (7) responding to and resolving all compliance-related issues that arise from the Ethics Action Line and compliance reports received from our facilities, hospital compliance officers or any other source; (8) ensuring that appropriate corrective and disciplinary actions are taken when non-compliant conduct or improper contractual relationships are identified; (9) monitoring and measuring adherence to all applicable Tenet policies and legal and regulatory requirements related to federal health care programs; (10) directing an annual screening of individuals for exclusion from federal health care program participation as required by federal regulations; (11) maintaining a database of all arrangements involving the payment of anything of value between Tenet and any physician or other actual or potential source of health care business or referrals to or from Tenet; and (12) overseeing annual audits of clinical quality, referral source arrangements, outliers, charging, coding, billing and other compliance risk areas as may be identified from time to time.

Standards of Conduct—All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Standards of Conduct* to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and many of our contractors are also required to abide by our *Standards of Conduct*. The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable laws and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

As part of the program, we provide annual training sessions to every employee, as well as our board of directors and certain physicians and contractors. All employees are required to report incidents that they believe in good faith may be in violation of the *Standards of Conduct*, and are encouraged to contact our 24-hour toll-free Ethics Action Line when they have questions about the standards or any ethics concerns. All reports to the Ethics Action Line are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. Incidents of alleged financial improprieties reported to the Ethics Action Line or the ethics and compliance department are communicated to the audit committee of our board of directors. Reported cases that involve a possible violation of the law or regulatory policies and procedures are referred to the ethics and compliance department for investigation. Retaliation against employees in connection with reporting ethical concerns is considered a serious violation of our *Standards of Conduct*, and, if it occurs, it will result in discipline, up to and including termination of employment.

Availability of Documents—The full text of our *Quality, Compliance and Ethics Program Charter,* our *Standards of Conduct*, and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the "Ethics and Compliance" caption in the "About" section. A copy of our *Standards of Conduct* is also available upon written request to our corporate secretary. Information about how to contact our corporate secretary is set forth under "Company Information" below. Amendments to the *Standards of Conduct* and any grant of a waiver from a provision of the *Standards of Conduct* requiring disclosure under applicable Securities and Exchange Commission ("SEC") rules will be disclosed at the same location as the *Standards of Conduct* on our website.

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INSURANCE

Property Insurance—We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Insurance—As is typical in the health care industry, we are subject to claims and lawsuits in the ordinary course of business. The health care industry has seen significant increases in the cost of professional liability insurance due to increased litigation. In response, we formed and maintain captive insurance companies to self-insure a substantial portion of our professional and general liability risk. We also own two captive insurance companies that write professional liability insurance for a small number of physicians, including employed physicians, who are on the medical staffs of certain of our hospitals.

Claims in excess of our self-insurance retentions are insured with commercial insurance companies. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital.

In addition to the reserves recorded by our captive insurance subsidiaries, we maintain reserves, including reserves for incurred but not reported claims, for our self-insured professional liability retentions and claims in excess of the policies' aggregate limits, based on actuarial estimates of losses and related expenses. Also, we provide standby letters of credit to certain of our insurers, which can be drawn upon under certain circumstances, to collateralize the deductible and self-insured retentions under a selected number of our professional and general liability insurance programs.

COMPANY INFORMATION

Tenet Healthcare Corporation was incorporated in the State of Nevada in 1975. We file annual, quarterly and current reports, proxy statements and other documents with the SEC under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Our reports, proxy statements and other documents filed electronically with the SEC are available at the website maintained by the SEC at www.sec.gov.

Our website, www.tenethealth.com, also offers, free of charge, access to our annual, quarterly and current reports (and amendments to such reports), and other filings made with, or furnished to, the SEC as soon as reasonably practicable after such documents are submitted to the SEC. The information found on our website is not part of this or any other report we file with or furnish to the SEC.

Inquiries directed to our corporate secretary may be sent to Corporate Secretary, Tenet Healthcare Corporation, P.O. Box 139003, Dallas, Texas 75313-9003 or by e-mail at CorporateSecretary@tenethealth.com.

FORWARD-LOOKING STATEMENTS

The information in this report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. These forward-looking statements represent management's current belief, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors — many of which we are unable to predict or control — that may cause our actual results, performance or achievements, or health care industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the following:

- The impact of the Affordable Care Act on our business and the enactment of, or changes in, laws and regulations affecting the health care industry generally;
- The effect that adverse economic conditions have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things;

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- Adverse litigation or regulatory developments;
- Our ability to enter into managed care provider arrangements on acceptable terms;
- Cuts to Medicare and Medicaid payment rates or changes in reimbursement practices;
- Competition;
- Our success in implementing our business development plans;
- Our ability to hire and retain qualified personnel, especially health care professionals;
- The availability and terms of capital to fund the expansion of our business, including the acquisition of additional facilities;
- Our success in marketing Conifer's revenue cycle management, health care information management, management services, and patient communications and engagement services to third-party hospitals and other healthcare-related entities;
- Our ability to realize fully or at all the anticipated benefits of our acquisition of Vanguard and to successfully integrate the operations of our business and Vanguard's business;
- Our ability to identify and execute on measures designed to save or control costs or streamline operations;
- The impact of our significant indebtedness; and
- Other factors and risks referenced in this report and our other public filings.

Also included among the foregoing factors are the positive and negative effects of health reform legislation on reimbursement and utilization, as well as the future design of provider networks and insurance plans, including pricing, provider participation, coverage, and co-pays and deductibles.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in this report. Should one or more of the risks and uncertainties described in this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statements. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

All forward-looking statements attributable to us are expressly qualified in their entirety by this cautionary statement.

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties — many of which are beyond our control — that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in the following risks were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment.

We cannot predict with certainty the ultimate net effect that the Affordable Care Act may have on our business, financial condition, results of operations or cash flows.

The Affordable Care Act is changing how health care services in the United States are covered, delivered and reimbursed. The expansion of health insurance coverage under the law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. However, it is difficult to predict the full impact of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding a number of material factors, including:

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- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);
- how many currently uninsured individuals will obtain coverage (either private health insurance or Medicaid) as a result of the Affordable Care Act;
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that the Affordable Care Act or components of it will be delayed, revised or eliminated as a result of court challenges or actions by Congress.

Furthermore, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. A substantial portion of both our patient volumes and, as result, our revenues is derived from government health care programs, principally Medicare and Medicaid. Any reductions to our reimbursement under the Medicare and Medicaid programs by the Affordable Care Act could adversely affect our business and results of operations to the extent such reductions are not offset by increased revenues from providing care to previously uninsured individuals. It is difficult to predict the effect on our revenues resulting from reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are implemented;
- whether future reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the size of the law's annual productivity adjustment to the market basket;
- the amount of the Medicare DSH reductions that will be made commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions commencing in FFY 2016;
- what the losses in revenues, if any, will be from the law's quality initiatives;
- how successful accountable care networks in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and

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- reductions to Medicare payments CMS may impose for "excessive readmissions."

In addition, the federally run exchanges, and several of the state-run exchanges, have faced operational hurdles and challenges in the initial period of their operation, which could reduce the number of individuals that obtain coverage through the exchanges in the short term. Further, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government health care program.

In general, there is significant uncertainty with respect to the positive and negative effects the Affordable Care Act may have on reimbursement, utilization and the future design of provider networks and insurance plans (including pricing, provider participation, coverage, co-pays and deductibles), and the multiple models that attempt to predict those effects may differ materially from our expectations. Because of the many variables involved, we are unable to predict the ultimate net effect on us of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Moreover, we are unable to predict the future course of federal, state and local health care regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

If we are unable to enter into and maintain managed care contractual arrangements on acceptable terms, if we experience material reductions in the contracted rates we receive from managed care payers or if we have difficulty collecting from managed care payers, our results of operations could be adversely affected.

We currently have thousands of managed care contracts with various HMOs and PPOs. The amount of our managed care net patient revenues during the year ended December 31, 2013 was $6.3 billion, which represented approximately 58% of our total net patient revenues before provision for doubtful accounts. Approximately 59% of our managed care net patient revenues for the year ended December 31, 2013 was derived from our top ten managed care payers. In the year ended December 31, 2013, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. In addition, at December 31, 2013, approximately 58% of our net accounts receivable related to continuing operations were due from managed care payers.

Our ability to negotiate favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. In addition, private payers are increasingly attempting to control health care costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. The trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. It is not clear what impact, if any, the increased obligations on private payers imposed by the health care reform law will have on our ability to negotiate reimbursement increases. However, as various provisions of the Affordable Care Act are implemented, including the establishment of the exchanges, non-government payers may increasingly demand reduced fees. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services, coupled with any difficulties in collecting receivables from managed care payers, could have a material adverse effect on our financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from private payers could be exacerbated if we are not able to manage our operating costs effectively.

Further changes in the Medicare and Medicaid programs or other government health care programs could have an adverse effect on our business.

For the year ended December 31, 2013, approximately 22% of our net patient revenues before provision for doubtful accounts for our general hospitals were related to the Medicare program, and approximately 9% of our net patient revenues before provision for doubtful accounts for our general hospitals were related to various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. In addition to the changes affected by the Affordable Care Act, the Medicare and Medicaid programs are subject to: other statutory and regulatory changes, administrative rulings, interpretations

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and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from government programs could be exacerbated if we are not able to manage our operating costs effectively.

Several states in which we operate continue to face budgetary challenges due to the economic downturn and other factors that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce their Medicaid expenditures. In addition, some states are implementing delays in issuing Medicaid payments to providers. As an alternative means of funding provider payments, most of the states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

In general, we are unable to predict the effect of future government health care funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government health care program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

The industry trend toward value-based purchasing may negatively impact our revenues.

We believe that value-based purchasing initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other health care facilities and may negatively impact our revenues if we are unable to meet expected quality standards. The Affordable Care Act contains a number of provisions intended to promote value-based purchasing in federal health care programs. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions, also known as HACs, unless the conditions were present at admission. Beginning in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year will receive reduced Medicare reimbursements. The Affordable Care Act also prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

There is a trend among private payers toward value-based purchasing of health care services, as well. Many large commercial payers require hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues if we are unable to meet quality standards established by both governmental and private payers.

Our business continues to be adversely affected by a high volume of uninsured and underinsured patients, as well as declines in commercial managed care patients.

Like other organizations in the health care industry, we continue to provide services to a high volume of uninsured patients and more patients than in prior years with increased burdens of co-pays and deductibles due to changes in their health care plans. As a result, we continue to experience a high level of uncollectible accounts, and, unless our business mix shifts toward a greater number of insured patients as a result of the Affordable Care Act or otherwise, the trend of higher co-pays and deductibles reverses, or the economy improves and unemployment rates decline, we anticipate this high level of uncollectible accounts to continue or increase. In addition, even after implementation of the Affordable Care Act, we may continue to experience significant levels of bad debt expense and have to provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance exchange or government health care program.

Over the past several years, we have experienced declines in our commercial managed care volumes, which in the aggregate generate substantially higher yields than Medicare and Medicaid volumes. The declines in our commercial managed

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care volumes are due, in part, to the related effects of higher unemployment and reductions in commercial managed care enrollment. In addition, we believe that the growth in high-deductible health plans has adversely impacted commercial managed care volumes.

Our hospitals, outpatient centers and other health care businesses operate in competitive environments, and competition is one reason increases in patient volumes have been constrained.

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities (1) are more established or newer than ours, (2) may offer a broader array of services to patients and physicians than ours, and (3) may have larger or more specialized medical staffs to admit and refer patients, among other things. Furthermore, health care consumers are now able to access hospital performance data on quality measures and patient satisfaction, as well as standard charges for services, to compare competing providers; if any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or patient satisfaction surveys, or if our standard charges are higher than our competitors, we may attract fewer patients. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

Continued consolidation in the health care industry will be a leading factor contributing to greater competition in our current markets and markets we may enter in the future. We also face increased competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high margin services and for quality physicians and personnel. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. As is the case with our hospitals, some of our health plan competitors are owned by governmental agencies or non-profit corporations that have greater financial resources than we do. If our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than we are, we may experience an overall decline in patient volumes

We could be subject to substantial uninsured liabilities or increased insurance costs as a result of significant legal actions.

We are subject to medical malpractice lawsuits, class action lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to such caps. Our professional and general liability insurance does not cover all claims against us, and it may not continue to be available at a reasonable cost for us to maintain at adequate levels, as the health care industry has seen significant increases in the cost of such insurance due to increased litigation. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

If we are unable to recruit and retain an appropriate number of quality physicians on the medical staffs of our hospitals, our business may suffer.

The success of our business depends in significant part on the number, quality and specialties of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and maintaining good relations with those physicians. Although we operate physician practices and, where permitted by law, employ physicians, physicians are often not employees of the hospitals at which they practice and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. Such physicians may terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment and hospital facilities that meet the

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needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

Our labor costs could be adversely affected by competition for staffing, the shortage of experienced nurses and labor union activity.

Our hospital operations depend on the efforts, abilities and experience of our management and medical support personnel, including nurses, pharmacists and lab technicians, as well as our employed physicians. We compete with other health care providers in recruiting and retaining physicians and qualified management responsible for the daily operations of our hospitals. In addition, like others in the health care industry, we continue to experience a shortage of seasoned nurses in certain key specialties and geographic areas. As a result, from time to time, we may be required to enhance wages and benefits to recruit and retain experienced nurses, make greater investments in education and training for newly licensed nurses, or hire more expensive temporary or contract personnel. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Increased labor union activity is another factor that could adversely affect our labor costs. At December 31, 2013, approximately 21% of our employees were represented by various labor unions. These employees — primarily registered nurses and service and maintenance workers — were located at 39 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating an initial contract at one of our hospitals where employees recently chose union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014; to the extent a greater portion of our employee base unionizes, it is possible our labor costs could increase materially.

Conifer's future success also depends in part on our ability to attract, hire, integrate and retain key personnel. Competition for the caliber and number of employees we require at Conifer is intense. We may face difficulty identifying and hiring qualified personnel at compensation levels consistent with our existing compensation and salary structure. In addition, we invest significant time and expense in training Conifer's employees, which increases their value to competitors who may seek to recruit them. If we fail to retain our Conifer employees, we could incur significant expenses in hiring, integrating and training their replacements, and the quality of Conifer's services and its ability to serve its customers could diminish, resulting in a material adverse effect on that segment of our business.

Our business and financial results could be harmed by violations of existing regulations or compliance with new or changed regulations.

Our business is subject to extensive federal, state and local regulation relating to, among other things, licensure, conduct of operations, privacy of patient information, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the health care industry are extremely complex and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. If a determination is made that we were in violation of such laws, rules or regulations, we could be subject to penalties or liabilities or required to make significant changes to our operations. In addition, Conifer's failure to comply with the laws and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its customers, or give customers the right to terminate Conifer's services agreements with them, among other things, any of which could have an adverse effect on Conifer's business. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on the value of our common stock and our business reputation could suffer. Furthermore, health care, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We are also required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

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Conifer operates in a highly competitive industry, and its current or future competitors may be able to compete more effectively than Conifer does, which could have a material adverse effect on Conifer's business, revenue, growth rate and market share.

We intend to continue expanding Conifer's revenue cycle management, patient communications and engagement services, and management services businesses by marketing these services to non-Tenet hospitals and other healthcare-related entities. However, the market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market (including software vendors and other technology-supported revenue cycle management outsourcing companies, traditional consultants and information technology outsourcing firms), as well as from the internal staffs of hospitals and other health care providers who, as described above, handle these processes internally. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Moreover, existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

The failure to comply with debt collection and consumer credit reporting regulations could subject Conifer's SOS subsidiary to fines and other liabilities, which could harm Conifer's reputation and business, and could make it more difficult for Conifer to retain existing customers or attract new customers.

The Fair Debt Collection Practices Act regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by SOS, Conifer's debt collection agency subsidiary, are subject to the FDCPA. Many states impose additional requirements on debt collection communications, and some of those requirements may be more stringent than the federal requirements. Moreover, regulations governing debt collection are subject to changing interpretations that may be inconsistent among different jurisdictions. SOS could be subject to fines or other penalties if it is determined to have violated the FDCPA, the Fair Credit Reporting Act or analogous state laws, which could make it more difficult to retain existing customers or attract new customers and could otherwise harm Conifer's business.

Our business could be negatively affected by security threats, catastrophic events and other disruptions affecting our information technology and related systems.

As a provider of health care services, we rely on our information technology in the day-to-day operation of our business to process, transmit and store sensitive or confidential data, including electronic health records, other protected health information, and financial, payment and other personal data of patients, as well as to store our proprietary and confidential business performance data. We utilize a diversified data and voice network, along with technology systems for billing, supply chain, clinical information systems and labor management. Although we have redundancies and other measures designed to protect the security and availability of the data we process, transmit and store, our information technology and infrastructure is vulnerable to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. Furthermore, our networks and technology systems are subject to disruption due to events such as a major earthquake, fire, telecommunications failure, terrorist attack or other catastrophic event. Any such breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact our ability to conduct normal business operations (including the collection of revenues), and could result in potential liability and damage to our reputation, any of which could have a material adverse effect on our business, financial position, results of operations or cash flows.

Economic downturns and other economic factors have affected, and may continue to impact, our business, financial condition and results of operations.

We continue to be impacted by a number of industry-wide challenges, including constrained growth in patient volumes and high levels of bad debt expense. We believe factors associated with the recent economic downturn — including higher levels of unemployment, reductions in commercial managed care enrollment, and patient decisions to postpone or cancel elective and non-emergency health care procedures — have affected our volumes and our ability to collect outstanding receivables. The U.S. economy remains volatile. Instability in consumer spending and high unemployment rates continue to pressure many industries.

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If industry trends or general economic conditions worsen, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Furthermore, the availability of liquidity and credit to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, to access those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions, and our ability to refinance existing debt. The economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under our senior secured revolving credit facility, causing them to fail to meet their obligations to us.

Trends affecting our actual or anticipated results may require us to record charges that would adversely affect our results of operations.

As a result of factors that have negatively affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospitals' most recent projections. If these projections are not met, or negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges. Future restructuring of our operating structure that changes our goodwill reporting units could also result in future impairments of our goodwill. Any such charges could adversely affect our results of operations.

The amount and terms of our current and any future debt could, among other things, adversely affect our ability to raise additional capital to fund our operations and limit our ability to react to changes in the economy or our industry.

As of December 31, 2013, we had approximately $10.8 billion of total long-term debt, as well as approximately $189 million in standby letters of credit outstanding under our senior secured revolving credit facility, which is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. From time to time, we expect to engage in additional capital market, bank credit and other financing activities depending on our needs and financing alternatives available at that time.

Our substantial indebtedness could have important consequences, including the following:

- Our credit agreement and indentures contain, and any future debt obligations may contain, covenants that, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. Our credit agreement also requires us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. The indentures contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions, or consolidate, merge or sell all or substantially all of our or their assets. If we do not comply with these obligations, it may cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

- We may be more vulnerable in the event of a deterioration in our business, in the health care industry or in the economy generally, or if federal or state governments set further limitations on reimbursement under the Medicare or Medicaid programs.

- We are required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which reduces the amount of funds available for our operations, capital expenditures and acquisitions.

- Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our credit agreement and the indentures governing our outstanding senior notes and senior secured notes. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

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We may be unable to successfully integrate Vanguard's business with our business to realize the anticipated benefits of the acquisition or do so within the intended timeframe.

The success of our acquisition of Vanguard will depend, in part, on our ability to integrate Vanguard's business and operations with our business and fully realize the anticipated benefits and synergies from combining our business with Vanguard's business. On October 1, 2013 (the effective date of the acquisition), we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans with approximately 140,000 members. As such, we are devoting significant management attention and resources to integrating the business practices and operations of Vanguard with ours. Potential difficulties we may encounter as part of the integration process include the following:

- The costs of integration and compliance and the possibility that the full benefits anticipated to result from the acquisition will not be realized;
- Delays in the integration of strategies, operations and services;
- Diversion of the attention of our management as a result of the acquisition;
- Differences in business backgrounds, corporate cultures and management philosophies that may delay successful integration;
- Retaining key executives and other employees;
- Challenges associated with creating and enforcing uniform standards, controls, procedures and policies;
- Complexities associated with managing Vanguard as a subsidiary of Tenet, including the challenge of integrating complex systems, technology, networks and other assets of Vanguard into those of Tenet in a manner that minimizes any adverse impact on patients, suppliers, employees and other constituencies;
- Potential unknown liabilities and unforeseen increased expenses or delays associated with the acquisition, including one-time cash costs to integrate Vanguard beyond current estimates; and
- The disruption of, or the loss of momentum in, our ongoing businesses.

If we are unable to successfully overcome the potential difficulties associated with the integration process and achieve our objectives following the acquisition, the anticipated benefits and synergies of the acquisition may not be realized fully, or at all, or may take longer to realize than expected. Any failure to timely realize these anticipated benefits could have a material adverse effect on our business, financial condition, results of operations or cash flows.

The utilization of our tax losses could be substantially limited if we experience an ownership change as defined in the Internal Revenue Code.

At December 31, 2013, we had federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax available to offset future taxable income. These NOL carryforwards will expire in the years 2024 to 2033. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount of taxable income we generate in future periods. There is no assurance that we will be able to fully utilize the NOL carryforwards. Furthermore, we could be required to record a valuation allowance related to the amount of the NOL carryforwards that may not be realized, which could impact our results of operations.

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ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The disclosure required under this Item is included in Item 1, Business, of this report.

ITEM 3. LEGAL PROCEEDINGS

For information regarding material pending legal proceedings in which we are involved, see Note 15 to our Consolidated Financial Statements, which is incorporated by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II.

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." On October 11, 2012, our common stock began trading on the NYSE on a split-adjusted basis following a one-for-four reverse stock split we announced on October 1, 2012. Every four shares of our issued and outstanding common stock were exchanged for one issued and outstanding share of common stock, without any change in the par value per share, and our authorized shares of common stock were proportionately decreased from 1,050,000,000 shares to 262,500,000 shares. No fractional shares were issued in connection with the stock split. The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock on the NYSE, as adjusted to reflect the reverse stock split:

	High	Low
Year Ended December 31, 2013		
First Quarter	$ 48.25	$ 33.00
Second Quarter	49.47	38.17
Third Quarter	47.08	36.87
Fourth Quarter	48.48	38.71
Year Ended December 31, 2012		
First Quarter	$ 24.20	$ 18.36
Second Quarter	22.56	17.32
Third Quarter	25.76	17.24
Fourth Quarter	33.86	22.86

On February 14, 2014, the last reported sales price of our common stock on the NYSE composite tape was $46.56 per share. As of that date, there were 4,356 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

Cash Dividends on Common Stock. We have not paid cash dividends on our common stock since the first quarter of fiscal 1994. We currently intend to retain future earnings, if any, for the operation and development of our business and, accordingly, do not currently intend to pay any cash dividends on our common stock. Our board of directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to pay any cash dividends in the future. Our senior secured revolving credit agreement contains provisions that limit the payment of cash dividends on our common stock if we do not meet certain financial ratios.

Equity Compensation. Refer to Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of Part III of this report for information regarding securities authorized for issuance under our equity compensation plans.

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to three indices, each of which includes us. The Standard & Poor's 500 Stock Index includes 500 companies representing all major industries. The Standard & Poor's Health Care Composite Index is a group of 55 companies involved in a variety of healthcare-related businesses. Because the Standard & Poor's Health Care Composite Index is heavily weighted by pharmaceutical and medical device companies, we believe that at times it may be less useful than the Hospital Management Peer Group Index included below. We compiled this Peer Group Index by selecting publicly traded companies that have as their primary business the management of acute care hospitals and that have been in business for all five of the years shown. These companies are: Community Health Systems, Inc. (CYH), Health Management Associates, Inc. (HMA), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS).

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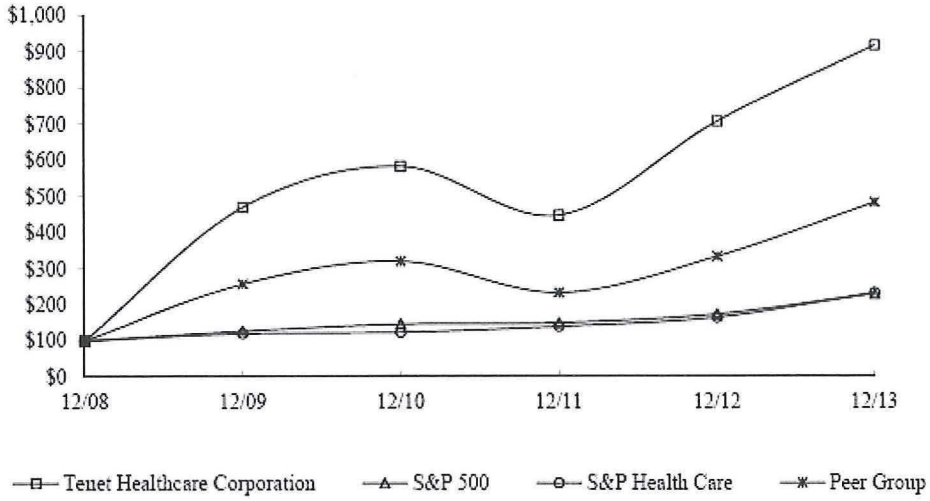
Performance data assumes that $100.00 was invested on December 31, 2008 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Stock price performance shown in the graph is not necessarily indicative of future stock price performance.

COMPARISON OF FIVE YEAR CUMULATIVE TOTAL RETURN



	12/08	12/09	12/10	12/11	12/12	12/13
Tenet Healthcare Corporation	$ 100.00	$ 468.70	$ 581.74	$ 446.09	$ 705.87	$ 915.65
S&P 500	$ 100.00	$ 126.46	$ 145.51	$ 148.59	$ 172.37	$ 228.19
S&P Health Care	$ 100.00	$ 119.70	$ 123.17	$ 138.85	$ 163.69	$ 231.55
Peer Group	$ 100.00	$ 256.65	$ 319.12	$ 232.26	$ 332.07	$ 481.22

Repurchase of Common Stock. In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Purchases during the year ended December 31, 2013 are shown in the table in Note 2 to our Consolidated Financial Statements, which table is incorporated by reference.

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ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2009 through 2013. Because we acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013, the 2013 columns in the tables below include results of operations for Vanguard and its consolidated subsidiaries for the three months ended December 31, 2013 only. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2013	2012	2011	2010	2009
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts	$ 12,074	$ 9,904	$ 9,371	$ 8,992	$ 8,785
Less: Provision for doubtful accounts	972	785	717	727	684
Net operating revenues	**11,102**	**9,119**	**8,654**	**8,265**	**8,101**
Operating expenses:					
Salaries, wages and benefits	5,371	4,257	4,015	3,830	3,781
Supplies	1,784	1,552	1,548	1,542	1,534
Other operating expenses, net	2,701	2,147	2,020	1,857	1,831
Electronic health record incentives	(96)	(40)	(55)	—	—
Depreciation and amortization	545	430	398	380	373
Impairment and restructuring charges, and acquisition-related costs	103	19	20	10	27
Litigation and investigation costs, net of insurance recoveries	31	5	55	12	31
Operating income	**663**	**749**	**653**	**634**	**524**
Interest expense	(474)	(412)	(375)	(424)	(445)
Gain (loss) from early extinguishment of debt	(348)	(4)	(117)	(57)	97
Investment earnings	1	1	3	5	—
Net gain on sales of investments	—	—	—	—	15
Income (loss) from continuing operations, before income taxes	**(158)**	**334**	**164**	**158**	**191**
Income tax benefit (expense)	65	(125)	(61)	977	23
Income (loss) from continuing operations, before discontinued operations and cumulative effect of change in accounting principle	**$ (93)**	**$ 209**	**$ 103**	**$ 1,135**	**$ 214**
Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	**$ (1.21)**	**$ 1.77**	**$ 0.58**	**$ 9.09**	**$ 1.67**
Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	**$ (1.21)**	**$ 1.70**	**$ 0.56**	**$ 8.03**	**$ 1.63**

The operating results data presented above is not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services ("CMS") of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; acquisition-related costs; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation

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allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related health care facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local health care competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us that impacts our relationships with physicians and patients; changes in health care regulations and the participation of individual states in federal programs; and the timing of elective procedures.

BALANCE SHEET DATA

	December 31,				
	2013	2012	2011	2010	2009
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 782	$ 918	$ 542	$ 586	$ 689
Total assets	16,130	9,044	8,462	8,500	7,953
Long-term debt, net of current portion	10,690	5,158	4,294	3,997	4,272
Total equity	878	1,218	1,492	1,819	697

CASH FLOW DATA

	Years Ended December 31,				
	2013	2012	2011	2010	2009
	(In Millions)				
Net cash provided by operating activities	$ 589	$ 593	$ 497	$ 472	$ 425
Net cash used in investing activities	(2,164)	(662)	(503)	(420)	(125)
Net cash provided by (used in) financing activities	1,324	320	(286)	(337)	(117)

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is Hospital Operations and other, which is focused on owning and operating acute care hospitals and outpatient facilities. We also operate revenue cycle management, patient communications and engagement services, and management services businesses under our Conifer Health Solutions, LLC ("Conifer") subsidiary, which is a separate reportable business segment. MD&A, which should be read in conjunction with the accompanying Consolidated Financial Statements, includes the following sections:

- Management Overview
- Sources of Revenue
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Recently Issued Accounting Standards
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day and per visit amounts). Continuing operations information includes the results of (i) our same-hospital operations, as described below, and (ii) Vanguard and its consolidated subsidiaries, which we acquired effective October 1, 2013, but only for the period from the date of acquisition through December 31, 2013. Continuing operations

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information excludes the results of our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. Same-hospital information includes the results of our operations for all periods presented, including the same 49 hospitals operated during the years ended December 31, 2013, 2012 and 2011 (and any interim periods in those years), but excludes the results of legacy Vanguard operations, as well as our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented. All amounts related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for the reverse stock split described in Item 5, Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities, of this report. Furthermore, certain prior-year amounts have been reclassified to conform to the current-year presentation.

MANAGEMENT OVERVIEW

STRATEGIES AND TRENDS

We are committed to providing the communities our hospitals, outpatient centers and other health care facilities serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed below.

Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to health care providers through Conifer. With respect to our hospitals and outpatient business, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology to remain competitive, to recruit and retain physicians, to increase the number of outpatient centers we own, and to negotiate favorable contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, our management services offerings have expanded to support value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We have made significant investments in the last decade in equipment, technology, education and operational strategies designed to improve clinical quality at our hospitals and outpatient centers. As a result of our efforts, our CMS Hospital Compare Core Measures scores have consistently exceeded the national average since the end of 2005, and major national private payers have also recognized our achievements relative to quality. These designations are expected to become increasingly important as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others. Through our *Commitment to Quality* and *Performance Excellence Program* initiatives, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effect of reducing costs, increasing payments from Medicare and certain managed care payers for our services, and increasing physician and patient satisfaction, which may improve our volumes.

Development Strategies—We remain focused on opportunities to increase our hospital and outpatient revenues through organic growth and acquisitions, and to expand our Conifer business.

From time to time, we build new facilities, make strategic acquisitions of health care assets and companies, and enter into joint venture arrangements or affiliations with health care businesses — in each case in markets where we believe our operating strategies can improve performance and create shareholder value. On October 1, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. During 2013, we also purchased: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. In addition, we entered into a partnership with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other health care services in the San Francisco Bay area, through which we will jointly develop and expand outpatient services and physician

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relationships to improve the efficiency and coordination of care in the Tri-Valley area and nearby communities in Northern California. Furthermore, we have signed a definitive agreement to acquire Emmanuel Medical Center, a 209-bed hospital located in Turlock, California.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the year ended December 31, 2013, we derived approximately 36% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. We believe that growth by strategic acquisitions, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. We continually evaluate collaboration opportunities with outpatient facilities, health care providers, physician groups and others in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality service across the care continuum.

We intend to continue expanding Conifer's revenue cycle management, patient communications and engagement services, and management services businesses by marketing these services to non-Tenet hospitals and other healthcare-related entities. Conifer provides services to more than 700 Tenet and non-Tenet hospital and other clients nationwide. We believe this business has the potential over time to generate high margins and improve our results of operations. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the health care industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals, clients for these services include health plans, self-insured employees and other entities.

Realizing HIT Incentive Payments and Other Benefits—Beginning in the year ended December 31, 2011, we achieved compliance with certain of the health information technology ("HIT") requirements under the American Recovery and Reinvestment Act of 2009 ("ARRA"). In 2013, we recognized approximately $96 million of Medicare electronic health record ("EHR") and Medicaid ARRA HIT incentives in our Consolidated Statement of Operations. These incentives partially offset the operating expenses we have incurred and continue to incur to invest in HIT systems. We expect to recognize additional incentives in the future. Furthermore, we believe that the operational benefits of HIT, including improved clinical outcomes and increased operating efficiencies, will contribute to our long-term ability to grow our business.

General Economic Conditions—We believe that high unemployment rates and other adverse economic conditions are continuing to have a negative impact on our bad debt expense levels, patient volumes and payer mix. However, as the economy recovers, we expect to experience improvements in these metrics relative to current levels.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. Increases in patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher patient co-pays and deductibles, and demographic trends. We continue to pursue integrated contracting models that maximize our system-wide skills and capabilities in conjunction with our strong market positions to accommodate new payment models. In several markets, we have formed clinical integration organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Most recently, in February 2014, we announced that our Abrazo Health network of hospitals in the Phoenix, Arizona area had signed an agreement enabling investment in the funding and expansion of Arizona Care Network. Under the terms of the agreement, Abrazo Health will have a 50% ownership interest in the Arizona Care Network, a clinically integrated network and ACO. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of Affordable Care Act—We anticipate that we will benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") that will extend insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by government payers, we anticipate that we will begin to receive reimbursement for caring for previously uninsured and underinsured patients as early as this year. Through collaborative efforts with local community organizations, we have launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans.

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Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is critical that we continue to make steady and measurable progress in 2014 in successfully integrating Vanguard's business and operations into our business processes. The benefits that come from our larger scale and combined expertise will be fully realized only when we are operating as one efficient and cohesive organization. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

RESULTS OF OPERATIONS—OVERVIEW

Selected Operating Statistics for All Continuing Operations Hospitals—The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the statistics from the hospitals included in the Vanguard acquisition only for the three months ended December 31, 2013. We believe this information is useful to investors because it reflects the significant increase to the scale of our operations as a result of our acquisition of Vanguard.

	Total Hospital Continuing Operations		
	Three Months Ended December 31,		
	2013	2012	Increase (Decrease)
Total admissions	190,506	125,290	52.1%
Adjusted patient admissions(1)	325,410	199,191	63.4%
Surgeries – inpatient	53,119	34,511	53.9%
Surgeries – outpatient	115,611	63,534	82.0%
Total surgeries	168,730	98,045	72.1%
Patient days – total	880,737	580,426	51.7%
Adjusted patient days(1)	1,481,291	915,231	61.8%
Average length of stay (days)	4.62	4.63	(0.2)%
Average licensed beds	20,294	13,216	53.6%
Utilization of licensed beds(2)	47.2%	47.7%	(0.5)%(3)
Total outpatient visits	1,875,684	1,053,499	78.0%
Net inpatient revenues	$ 2,372	$ 1,544	53.6%
Net outpatient revenues	$ 1,357	$ 821	65.3%
Net inpatient revenue per admission	$ 12,451	$ 12,323	1.0%
Net inpatient revenue per patient day	$ 2,693	$ 2,660	1.2%
Net outpatient revenue per visit	$ 723	$ 779	(7.2)%
Net patient revenue per adjusted admission	$ 11,459	$ 11,873	(3.5)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.
(3) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Operating Statistics on a Same-Hospital Basis—Our results of operations have been and continue to be influenced by industry-wide and company-specific challenges, including constrained volume growth and high levels of bad debt, that have affected our revenue growth and operating expenses. We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2013 and 2012 on a same-hospital basis, where noted, excluding the results of the 28 hospitals we acquired from Vanguard on October 1, 2013.

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Admissions, Patient Days and Surgeries	Same-Hospital Continuing Operations Three Months Ended December 31, 2013	2012	Increase (Decrease)
Total admissions	122,404	125,290	(2.3)%
Adjusted patient admissions(1)	198,129	199,191	(0.5)%
Paying admissions (excludes charity and uninsured)	113,573	116,611	(2.6)%
Charity and uninsured admissions	8,831	8,679	1.8%
Admissions through emergency department	76,872	77,465	(0.8)%
Paying admissions as a percentage of total admissions	92.8%	93.1%	(0.3)%(2)
Charity and uninsured admissions as a percentage of total admissions	7.2%	6.9%	0.3%(2)
Emergency department admissions as a percentage of total admissions	62.8%	61.8%	1.0%(2)
Surgeries – inpatient	34,198	34,511	(0.9)%
Surgeries – outpatient	84,878	63,534	33.6%
Total surgeries	119,076	98,045	21.5%
Patient days – total	574,796	580,426	(1.0)%
Adjusted patient days(1)	920,975	915,231	0.6%
Average length of stay (days)	4.70	4.63	1.5%
Average licensed beds	13,179	13,216	(0.3)%
Utilization of licensed beds(3)	47.4%	47.7%	(0.3)%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Total same-hospital admissions decreased by 2,886, or 2.3%, in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. Total surgeries increased by 21.5% in the three months ended December 31, 2013 compared to the same period in 2012, comprised of a 33.6% increase in outpatient surgeries partially offset by a 0.9% decrease in inpatient surgeries. Our emergency department admissions decreased 0.8% in the three months ended December 31, 2013 compared to the same period in the prior year. We believe the current economic conditions continue to have an adverse impact on the level of elective procedures performed at our hospitals, which contributed to the decrease in our total admissions. Charity and uninsured admissions increased 1.8% in the three months ended December 31, 2013 compared to the three months ended December 31, 2012, while paying admissions decreased 2.6%.

Outpatient Visits	Same-Hospital Continuing Operations Three Months Ended December 31, 2013	2012	Increase (Decrease)
Total visits	1,088,194	1,053,499	3.3%
Paying visits (excludes charity and uninsured)	974,396	941,658	3.5%
Charity and uninsured visits	113,798	111,841	1.7%
Emergency department visits	404,950	399,711	1.3%
Surgery visits	84,878	63,534	33.6%
Paying visits as a percentage of total visits	89.5%	89.4%	0.1%(1)
Charity and uninsured visits as a percentage of total visits	10.5%	10.6%	(0.1)%(1)

(1) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Total same-hospital outpatient visits increased 34,695, or 3.3%, in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. All four of our same-hospital regions and our Philadelphia market reported increased outpatient visits in the three months ended December 31, 2013, with the strongest growth occurring in our California and Florida regions. Approximately 39% of the growth in outpatient visits was organic.

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Outpatient surgery visits increased by 33.6% in the three months ended December 31, 2013 compared to the same period in 2012. Charity and uninsured outpatient visits increased by 1.7% in the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Revenues	2013	2012	Increase (Decrease)
Net operating revenues	$ 2,471	$ 2,331	6.0%
Revenues from the uninsured	$ 169	$ 165	2.4%
Net inpatient revenues(1)	$ 1,521	$ 1,544	(1.5)%
Net outpatient revenues(1)	$ 864	$ 821	5.2%

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $72 million and $71 million for the three months ended December 31, 2013 and 2012, respectively. Net outpatient revenues include self-pay revenues of $97 million and $94 million for the three months ended December 31, 2013 and 2012, respectively.

Net operating revenues increased by $140 million, or 6.0%, on a same-hospital basis in the three months ended December 31, 2013 compared to the same period in 2012, primarily due to an increase in outpatient volumes, improved managed care pricing, and increased revenues from services provided by our Conifer subsidiary to third parties, partially offset by a decrease in inpatient volumes. Net operating revenues in the three months ended December 31, 2013 included $71 million of Medicaid disproportionate share hospital ("DSH") and other state-funded subsidy revenues compared to $72 million in the same period in 2012 on a same-hospital basis, which amounts included net revenues related to the California provider fee program of $19 million and $12 million, respectively. Net patient revenues increased by 0.8% in the three months ended December 31, 2013 compared to the same period in 2012.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2013	2012	Increase (Decrease)
Net inpatient revenue per admission	$ 12,426	$ 12,323	0.8%
Net inpatient revenue per patient day	$ 2,646	$ 2,660	(0.5)%
Net outpatient revenue per visit	$ 794	$ 779	1.9%
Net patient revenue per adjusted patient admission(1)	$ 12,038	$ 11,873	1.4%
Net patient revenue per adjusted patient day(1)	$ 2,590	$ 2,584	0.2%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Net inpatient revenue per admission increased 0.8% in the three months ended December 31, 2013 compared to the same period in 2012. The increase primarily reflects improved terms in our contracts with commercial managed care payers, partially offset by an adverse shift in payer mix. The 1.9% increase in net outpatient revenue per visit was primarily due to the improved terms of our managed care contracts.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Provision for Doubtful Accounts	2013	2012	Increase (Decrease)
Provision for doubtful accounts	$ 205	$ 200	2.5%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.7%	7.9%	(0.2)%(1)
Collection rate on self-pay accounts(2)	28.7%	28.9%	(0.2)%(1)
Collection rate on commercial managed care accounts	98.3%	98.0%	0.3%(1)

(1) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

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Provision for doubtful accounts increased by $5 million, or 2.5%, in the three months ended December 31, 2013 compared to the same period in 2012. The increase in the absolute amount of provision for doubtful accounts primarily related to an increase in uninsured patient revenues and higher patient co-pays and deductibles in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. Our self-pay collection rate, which is the blended collection rate for uninsured and balance after insurance accounts receivable, was approximately 28.7% at December 31, 2013 and 28.9% at December 31, 2012.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Selected Operating Expenses	2013	2012	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,050	$ 1,010	4.0%
Supplies	397	388	2.3%
Other operating expenses	535	506	5.7%
Total	$ 1,982	$ 1,904	4.1%
Conifer			
Salaries, wages and benefits	$ 169	$ 81	108.6%
Other operating expenses	59	37	59.5%
Total	$ 228	$ 118	93.2%
Total			
Salaries, wages and benefits	$ 1,219	$ 1,091	11.7%
Supplies	397	388	2.3%
Other operating expenses	594	543	9.4%
Total	$ 2,210	$ 2,022	9.3%
Rent/lease expense(1)			
Hospital Operations and other	$ 35	$ 39	(10.3)%
Conifer	4	3	33.3%
Total	$ 39	$ 42	(7.1)%
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,138	$ 1,103	3.2%
Supplies per adjusted patient day	431	424	1.7%
Other operating expenses per adjusted patient day	562	553	1.6%
Total per adjusted patient day	$ 2,131	$ 2,080	2.5%
Salaries, wages and benefits per adjusted patient admission	$ 5,289	$ 5,071	4.3%
Supplies per adjusted patient admission	2,004	1,948	2.9%
Other operating expenses per adjusted patient admission	2,615	2,540	3.0%
Total per adjusted patient admission	$ 9,908	$ 9,559	3.7%

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

Total selected operating expenses, which is defined as salaries, wages and benefits, supplies and other operating expenses, increased by 2.5% and 3.7% on a per adjusted patient day and per adjusted patient admission basis, respectively, in the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Salaries, wages and benefits per adjusted patient admission increased by approximately 4.3% in the three months ended December 31, 2013 compared to the same period in 2012. This increase is primarily due to an increase in the number of physicians we employ, annual merit increases for certain of our employees and increased contract labor expense in the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Supplies expense per adjusted patient admission increased by 2.9% in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. The increase in supplies expense was primarily attributable to increased costs of pharmaceuticals and volume growth in our supply-intensive surgical services.

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Other operating expenses per adjusted patient admission increased by 3.0% in the three months ended December 31, 2013 compared to the same period in 2012. This change is primarily due to increased medical fees related to employed physicians and increased malpractice expense, partially offset by decreases in legal and consulting costs. Malpractice expense in the 2013 period included a favorable adjustment of approximately $3 million due to a 43 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an favorable adjustment of $1 million as a result of a 14 basis point increase in the interest rate in the 2012 period.

Salaries, wages and benefits expense for Conifer increased by $88 million in the three months ended December 31, 2013 compared to the three months ended December 31, 2012 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the new CHI partnership, the Vanguard acquisition and Conifer's two acquisitions in the three months ended December 31, 2012.

Other operating expenses for Conifer increased by $22 million in the three months ended December 31, 2013 compared to the three months ended December 30, 2012 primarily due to additional operating expenses related to the new CHI partnership, the Vanguard acquisition and Conifer's two acquisitions in the three months ended December 31, 2012.

The table below shows the pre-tax and after-tax impact on continuing operations for the three months and years ended December 31, 2013 and 2012 of the following items:

	Three Months Ended December 31,		Years Ended December 31,	
	2013	2012	2013	2012
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (58)	$ (7)	$ (103)	$ (19)
Litigation and investigation costs	(28)	(2)	(31)	(5)
Loss from early extinguishment of debt	—	(4)	(348)	(4)
Pre-tax impact	$ (86)	$ (13)	$ (482)	$ (28)
Total after-tax impact	$ (60)	$ (8)	$ (315)	$ (18)
Diluted per-share impact of above items	$ (0.60)	$ (0.08)	$ (3.06)	$ (0.17)
Diluted earnings (loss) per share, including above items	$ (0.17)	$ 0.52	$ (1.21)	$ 1.70

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $113 million at December 31, 2013, an increase of $31 million from $82 million at September 30, 2013.

Significant cash flow items in the three months ended December 31, 2013 included:

- Capital expenditures of $293 million;
- Interest payments of $131 million;
- Payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements of $78 million;
- $195 million of net proceeds from borrowings under our revolving credit facility;
- $1.373 billion of payments to acquire Vanguard and various outpatient, physician practice and other healthcare-related businesses, net of cash acquired;
- $100 million of payments to repurchase common stock;
- $3.125 billion of payments to retire Vanguard long-term debt; and
- $4.600 billion of proceeds from the issuance of our 6% senior secured notes due 2020 ($1.800 billion) and 8 1/8% senior notes due 2020 ($2.800 billion).

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Net cash provided by operating activities was $589 million in the year ended December 31, 2013 compared to $593 million in the year ended December 31, 2012. Key negative and positive factors contributing to the change between the 2013 and 2012 periods include the following:

- Increased income from continuing operations before income taxes of $139 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, litigation and investigation costs, impairment and restructuring charges, acquisition-related costs, and depreciation and amortization in the year ended December 31, 2013 compared to the year ended December 31, 2012;
- The unfavorable impact of increased DSH receivables of $30 million primarily related to the Texas uncompensated care 1115 waiver program;
- $20 million less cash used in operating activities from discontinued operations;
- An increase of $51 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;
- $50 million of additional interest payments primarily due to $37 million of interest payments related to the Vanguard debt refinanced in connection with the acquisition on October 1, 2013; and
- Income tax payments of $6 million in the year ended December 31, 2013 compared to $13 million in the year ended December 31, 2012.

SOURCES OF REVENUE

We receive revenues for patient services from a variety of sources, primarily managed care payers and the federal Medicare program, as well as state Medicaid programs, indemnity-based health insurance companies and self-pay patients (that is, patients who do not have health insurance and are not covered by some other form of third-party arrangement).

The table below shows the sources of net patient revenues before provision for doubtful accounts for our general hospitals, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Years Ended December 31,		
Net Patient Revenues from:	**2013**	**2012**	**2011**
Medicare	21.8%	23.4%	23.1%
Medicaid	9.0%	8.4%	9.0%
Managed care	58.1%	57.4%	57.2%
Indemnity, self-pay and other	11.1%	10.8%	10.7%

Our payer mix on an admissions basis for our general hospitals, expressed as a percentage of total admissions from all sources, is shown below:

	Years Ended December 31,		
Admissions from:	**2013**	**2012**	**2011**
Medicare	28.0%	28.9%	29.6%
Medicaid	11.7%	12.2%	12.8%
Managed care	50.0%	48.8%	47.9%
Indemnity, self-pay and other	10.3%	10.1%	9.7%

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GOVERNMENT PROGRAMS

The Medicare program, the nation's largest health insurance program, is administered by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services ("HHS"). Medicare is a health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources, and is jointly funded by the federal government and state governments. Medicaid is the largest source of funding for medical and health-related services for the nation's poor and most vulnerable individuals.

The Affordable Care Act is changing how health care services in the United States are covered, delivered and reimbursed. One key provision of the Affordable Care Act is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. For individuals who are not exempt from the individual mandate, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Also beginning in 2014, those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty. The "employer mandate" provision of the Affordable Care Act requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. On July 2, 2013, the U.S. Treasury Department announced a one-year delay (to January 1, 2015) in the imposition of penalties and the reporting requirements of the employer mandate. On February 10, 2014, the requirements of the employer mandate were further delayed until January 1, 2016. Based on the Congressional Budget Office's most recent estimates, we do not believe that the delays in the employer mandate will have a discernible effect on insurance coverage. Another key provision of the Affordable Care Act is the expansion of Medicaid coverage. Prior to the passage of the ACA, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The ACA expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. The expansion of the Medicaid program (which will be substantially funded by the federal government) in each state will require state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. As of December 31, 2013, 25 states and the District of Columbia have taken action to expand Medicaid and four others are considering action. We currently operate hospitals in five of the states that are expanding and two of the states that are considering expansion. We cannot provide any assurances as to whether or when the other states in which we operate might choose to expand their Medicaid programs. We anticipate that health care providers will generally benefit over time from insurance coverage provisions of the Affordable Care Act; however, the ACA also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including: (1) negative adjustments to the annual market basket updates for Medicare inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and (2) reductions to Medicare and Medicaid DSH payments beginning, with respect to Medicare payments, in federal fiscal year ("FFY") 2014 and, with respect to Medicaid payments, in FFY 2016, as the number of uninsured individuals declines. We are unable to predict the ultimate net effect of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding the ultimate number of uninsured patients who will obtain insurance coverage, uncertainty regarding future negotiations with payers, uncertainty regarding Medicaid expansion, and gradual and, in some cases, delayed implementation. Furthermore, we are unable to predict what action, if any, Congress might take with respect to the Affordable Care Act or the actions individual states might take with respect to expanding Medicaid coverage.

The Medicare and Medicaid programs are also subject to statutory and regulatory changes, administrative and judicial rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are unable to predict the effect of future government health care funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government health care program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage

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(sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues, including our general hospitals and other operations, for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2013, 2012, and 2011 are set forth in the following table:

	Years Ended December 31,		
Revenue Descriptions	**2013**	**2012**	**2011**
Medicare severity-adjusted diagnosis-related group – operating	$ 1,201	$ 1,109	$ 1,126
Medicare severity-adjusted diagnosis-related group – capital	107	98	100
Outliers	53	51	44
Outpatient	632	522	462
Disproportionate share	250	217	214
Direct Graduate and Indirect Medical Education(1)	138	96	97
Other(2)	42	66	70
Adjustments for prior-year cost reports and related valuation allowances	32	109	—
Total Medicare net patient revenues	**$ 2,455**	**$ 2,268**	**$ 2,113**

(1) Includes Indirect Medical Education revenue earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.

(2) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

A general description of the types of payments we receive for services provided to patients enrolled in the Original Medicare Plan is provided below. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found below under "Regulatory and Legislative Changes."

Acute Care Hospital Inpatient Prospective Payment System

Medicare Severity-Adjusted Diagnosis-Related Group Payments—Sections 1886(d) and 1886(g) of the Social Security Act (the "Act") set forth a system of payments for the operating and capital costs of inpatient acute care hospital admissions based on a prospective payment system ("PPS"). Under the inpatient prospective payment systems ("IPPS"), Medicare payments for hospital inpatient operating services are made at predetermined rates for each hospital discharge. Discharges are classified according to a system of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), which categorize patients with similar clinical characteristics that are expected to require similar amounts of hospital resources. CMS assigns to each MS-DRG a relative weight that represents the average resources required to treat cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. Using diagnosis and procedure information submitted by the hospital, CMS assigns to each discharge an MS-DRG, and the base payments are multiplied by the relative weight of the MS-DRG assigned. The MS-DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not take into consideration an individual hospital's operating and capital costs.

Outlier Payments— Outlier payments are additional payments made to hospitals on individual claims for treating Medicare patients whose medical conditions are costlier to treat than those of the average patient in the same MS-DRG. To qualify for a cost outlier payment, a hospital's billed charges, adjusted to cost, must exceed the payment rate for the MS-DRG by a fixed threshold established annually by CMS. A Medicare administrative contractor ("MAC") calculates the cost of a claim by multiplying the billed charges by a cost-to-charge ratio that is typically based on the hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Act, CMS must project aggregate annual outlier payments to all PPS hospitals to be not less than 5% or more than 6% of total MS-DRG payments ("Outlier Percentage"). The Outlier Percentage is determined by dividing total outlier

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payments by the sum of MS-DRG and outlier payments. CMS annually adjusts the fixed threshold to bring projected outlier payments within the mandated limit. A change to the fixed threshold affects total outlier payments by changing: (1) the number of cases that qualify for outlier payments; and (2) the dollar amount hospitals receive for those cases that still qualify for outlier payments.

Disproportionate Share Hospital Payments— In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately high share of low-income patients. Prior to October 1, 2013, DSH payments were determined annually based on certain statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. Section 3133 of the Affordable Care Act revises the Medicare DSH adjustment effective for discharges occurring on or after October 1, 2014. Under the revised methodology, hospitals will receive 25% of the amount they previously would have received under the pre-ACA formula. This amount is referred to as the "Empirically Justified Amount."

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC DSH Amount"). The UC DSH Amount is a hospital's share of a pool of funds that equal 75% of what otherwise would have been paid as Medicare DSH, adjusted for changes in the percentage of individuals that are uninsured. For FFY 2014, each Medicare DSH hospital's share of the UC DSH Amount pool is based on its share of insured low income days reported by all Medicare DSH hospitals.

During 2013, 68 of our hospitals in continuing operations qualified for DSH payments. One of the variables used in the pre-ACA DSH formula is the number Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Medicare Traditional patients, but also Medicare Advantage patients in the SSI ratio. During the three months ended March 31, 2012, CMS released revised SSI ratios for FFYs 2006 and 2007, and SSI ratios for FFYs 2008 and 2009, which, according to CMS, include the Medicare Advantage days; the SSI ratios for subsequent periods also include the Medicare Advantage days. Beginning in 2009, we established reserves for the estimated impact of including the Medicare Advantage days in the SSI ratio, and during 2013, cost report settlements for substantially all of the periods for which we established reserves were settled.

The Medicare DSH statutes and regulations have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in these appeals, including challenges to the inclusion of Medicare Advantage days in the SSI ratios. These types of appeals generally take several years to resolve, particularly for multi-hospital organizations, because of CMS' administrative appeal rules. During the three months ended December 31, 2012, the federal district court in the District of Columbia ruled in *Allina Health Services v. Sebelius ("Allina")* that the Secretary of HHS failed to follow the Administrative Procedures Act when promulgating the regulation requiring the inclusion of the Medicare Advantage days in the SSI ratios. The court remanded the matter to the Secretary and vacated the regulation it found to be improperly promulgated. Subsequently, the Secretary appealed the district court's order. Oral arguments in *Allina* were heard at the U.S. Court of Appeals for the D.C. Circuit Court in February 2014. Our DSH SSI appeals are pending; however, the outcome of the aforementioned case could influence the disposition of our appeals. We cannot predict the timing or outcome of our DSH appeals; however, a favorable outcome of our appeals could have a material impact on our future revenues and cash flows. We are also not able to predict what additional action the Secretary might take with respect to the regulation vacated by the district court.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") payments. During 2013, 29 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments. Medicare rules permit teaching hospitals to enter into Medicare Graduate Medical Education Affiliation Agreements for the purpose of applying the FTE limits on an aggregate basis, and some of our teaching hospitals have entered into such agreements.

Hospital Outpatient Prospective Payment System

Under the outpatient prospective payment system, hospital outpatient services, except for certain services that are reimbursed on a separate fee schedule, are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require, and a payment rate is established for each APC.

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Depending on the services provided, hospitals may be paid for more than one APC for an encounter. CMS periodically updates the APCs and annually adjusts the rates paid for each APC.

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient prospective payment system. The IPF-PPS is based on prospectively determined per-diem rates and includes an outlier policy that authorizes additional payments for extraordinarily costly cases.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system.

To be paid under the IRF-PPS, each hospital or unit must demonstrate on an annual basis that at least 60% of its total population had either a principal or secondary diagnosis that fell within one of 13 diagnosis categories or have qualifying conditions designated in the Medicare regulations governing IRFs. As of December 31, 2013, all of our rehabilitation units were in compliance with the required 60% threshold.

Physician Services Payment System

Medicare pays for physician and other professional services based on a list of services and their payment rates, called the Medicare Physician Fee Schedule ("MPFS"). In determining payment rates for each service on the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations and other factors. The conversion factor updates payments for physician services every year according to a formula called the sustainable growth rate ("SGR") system. This formula is intended to keep spending growth (a function of service volume growth) consistent with growth in the national economy. However, in the last several years, Congress has specified an update outside of the SGR formula. Because of budget neutrality requirements, these payment updates have largely been funded by payment reductions to other providers, including hospitals.

Cost Reports

The final determination of certain Medicare payments to our hospitals, such as DSH, DGME, IME and bad debt expense, are retrospectively determined based on our hospitals' cost reports. The final determination of these payments often takes many years to resolve because of audits by the program representatives, providers' rights of appeal, and the application of numerous technical reimbursement provisions.

For filed cost reports, we adjust the accrual for estimated cost report settlements based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for estimated cost report settlements for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports and a corresponding valuation allowance is recorded as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, excluding state-funded managed care Medicaid programs, constituted approximately 9.0%, 8.4% and 9.0% of net patient revenues before provision for doubtful accounts at our continuing general hospitals for the years ended December 31, 2013, 2012 and 2011, respectively. We also receive DSH payments under various state Medicaid programs. For the years ended December 31, 2013, 2012 and 2011, our revenues attributable to DSH payments and other state-funded subsidy payments were approximately $428 million, $283 million

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and $255 million, respectively. The 2013 amount includes three months of revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013.

Several states in which we operate continue to face budgetary challenges due to the economic downturn and other factors that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce their Medicaid expenditures. In addition, some states are implementing delays in issuing Medicaid payments to providers. As an alternative means of funding provider payments, many of the states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

During the year ended December 31, 2013, we recorded net revenues of $115 million related to California Hospital Quality Assurance Fee ("HQAF") program. The Governor of California signed the HQAF renewal bill into law in October 2013, extending California's provider fee program for three years (with a framework to renew the program for at least three additional years beyond 2016) and reversing Medi-Cal cuts for some hospital skilled-nursing facilities, among other things. Based on the most recent estimates from the California Hospital Association, the extension of the HQAF program authorized by the legislation will result in additional revenues for our hospitals, net of provider fees and other expenses, of approximately $475 million over the three-year period ending December 31, 2016.

During the three months ended December 31, 2012, certain of our Texas hospitals began to participate in the Texas 1115 demonstration waiver approved by CMS in December 2011 to replace the state's Upper Payment Limit program. The waiver term covers state fiscal years September 1, 2012 through August 31, 2016, is funded by intergovernmental transfer payments from local government entities, and includes two funding pools — Uncompensated Care and Delivery System Reform Payment. We recognized $15 million of revenues associated with this 1115 waiver program during the three months ended December 31, 2012. Separately, during the same period we incurred $13 million of expenses related to funding indigent care services by certain of our Texas hospitals. In 2013, we recognized $94 million of revenues from the Texas 1115 waiver programs, and we incurred $55 million of expense related to funding indigent care services by certain of our Texas hospitals. We cannot provide any assurances as to the ultimate amount of revenues that our hospitals may receive from this program in 2014.

Because we cannot predict what actions the federal government or the states may take under existing legislation and future legislation to address budget gaps or deficits, we are unable to assess the effect that any such legislation might have on our business, but the impact on our future financial position, results of operations or cash flows could be material.

Medicaid-related patient revenues recognized by our continuing general hospitals from Medicaid-related programs in the states in which they are located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2013, 2012 and 2011 are set forth in the table below:

	Years Ended December 31,					
	2013		2012		2011	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
California	$ 242	$ 164	$ 198	$ 148	$ 221	$ 127
Florida	178	65	178	61	184	60
Texas	151	151	67	123	64	114
Georgia	77	35	85	38	88	40
Pennsylvania	74	200	72	209	91	195
Michigan	64	96	—	—	—	—
Missouri	64	6	70	5	52	5
North Carolina	34	5	40	—	23	—
Illinois	33	6	—	—	—	—
South Carolina	22	25	34	25	40	22
Alabama	13	—	31	—	29	—
Arizona	9	21	—	—	—	—
Massachusetts	9	8	—	—	—	—
Tennessee	6	27	8	29	10	30
	$ 976	**$ 809**	**$ 783**	**$ 638**	**$ 802**	**$ 593**

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Regulatory and Legislative Changes

Recent regulatory and legislative updates to the Medicare and Medicaid payment systems are provided below.

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the IPPS. The updates generally become effective October 1, the beginning of the federal fiscal year. On August 2, 2013, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2014 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.5% for MS-DRG operating payments for hospitals reporting specified quality measure data (hospitals that do not report specified quality measure data would receive an increase of 0.5%); CMS is also making certain adjustments to the 2.5% market basket increase that result in a net market basket update of 0.7%, including:
  - Market basket index and multifactor productivity reductions required by the Affordable Care Act of 0.3% and 0.5%, respectively;
  - A documentation and coding recoupment reduction of 0.8% as part of the recoupment required by the American Taxpayer Relief Act of 2012; and
  - A 0.2% reduction to offset the cost of a policy on admission and medical review criteria;
- A methodology to implement Medicare DSH reductions required by the Affordable Care Act;
- A 0.9% net increase in the capital federal MS-DRG rate; and
- A decrease in the cost outlier threshold from $21,821 to $21,748.

The aforementioned admission and medical review criteria for which CMS imposed a 0.2% reduction to the market basket establishes a new policy (referred to as "the two-midnight rule") with respect to how short hospital stays will be paid. Generally, under the two-midnight rule, claims for inpatient admissions spanning two or more midnights may continue to be billed as inpatient care under the IPPS. The new policy requires, with a few limited exceptions, hospital stays that are shorter than "two midnights" to be categorized as outpatient care and billed under the OPPS. In September 2013, CMS instructed its contractors to delay enforcement of the two-midnight rule for 90 days; CMS subsequently extended the enforcement delay through September 30, 2014. Our hospitals, along with many other hospitals nationally, are participating in a challenge to CMS's calculation of the 0.2% reduction to the IPPS market basket associated with the two-midnight rule.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 1.0% increase in payments for hospitals in large urban areas (populations over one million). Using the impact percentages in the Final IPPS Rule as applied to our IPPS payments for the 12 months ended September 30, 2013, the estimated annual impact for all changes in the Final IPPS Rule on our hospitals is an increase in our Medicare inpatient revenues of approximately $23 million. Because of the uncertainty associated with the other factors that may influence our future IPPS payments by individual hospital, including legislative action, regulatory and policy changes, admission volumes, length of stay, case mix, the redistributive effects of the Medicare DSH reductions and the two-midnight rule, we cannot provide any assurances regarding our estimate.

Payment Changes to the Medicare Inpatient Psychiatric Facility Prospective Payment System

On July 29, 2013, CMS issued a notice updating the prospective payment rates for the Medicare inpatient psychiatric facility ("IPF") prospective payment system ("IPF-PPS") for FFY 2014 ("IPF-PPS Notice"). The IPF-PPS Notice includes the following payment and policy changes:

- A net payment increase for IPFs of 2.0%, which reflects a market basket index increase of 2.6%, reduced by a productivity adjustment of 0.5% and an additional 0.1%, both as required by the Affordable Care Act, as well as other adjustments, including a budget neutrality reduction; and

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- A decrease in the outlier threshold from $11,600 to $10,245, which CMS estimates will yield an additional 0.3% increase total IPF-PPS payments.

At December 31, 2013, 18 of our general hospitals operated inpatient psychiatric units reimbursed under the IPF-PPS. CMS projects that the combined impact of the payment and policy changes included in the IPF-PPS Notice will yield an average 2.3% increase in payments for all IPFs (including psychiatric units in acute care hospitals) and an average 2.5% increase in payments for psychiatric units of acute care hospitals located in urban areas for FFY 2014. Using the urban psychiatric unit impact percentage as applied to our IPF-PPS payments for the 12 months ended September 30, 2013, the annual impact of all payment and policy changes in the IPF-PPS Notice on our IPF-PPS psychiatric units may result in an estimated increase in our Medicare revenues of approximately $1 million. Because of the uncertainty associated with various factors that may influence our future IPF-PPS payments, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the aforementioned changes.

Payment and Policy Changes to the Medicare Inpatient Rehabilitation Facility Prospective Payment System

On July 31, 2013, CMS issued final changes to the Medicare inpatient rehabilitation facility ("IRF") prospective payment system ("IRF-PPS") for FFY 2014 ("IRF-PPS Final Rule"). The IRF-PPS Final Rule includes the following payment and policy changes:

- A net update to IRF-PPS payments equal to 1.8% resulting from the estimated market basket of 2.6%, minus an estimated productivity adjustment of 0.5% and a market basket reduction of 0.3%, both of which are required under certain provisions of the Affordable Care Act; and

- A reduction in the number of diagnosis codes from the list used to determine an IRF's presumptive compliance with the "60 percent rule."

At December 31, 2013, 16 of our general hospitals operated inpatient rehabilitation units. CMS projects that the payment changes in the IRF-PPS Final Rule will result in an estimated total increase in aggregate IRF payments of 2.3%. This estimated increase includes an average 2.8% increase for rehabilitation units in hospitals located in urban areas for FFY 2014. Using the urban rehabilitation unit impact percentage as applied to our Medicare IRF payments for the 12 months ended September 30, 2013, the annual impact of the payment and policy changes in the IRF-PPS Final Rule on the inpatient rehabilitation units we operated on that date may result in an estimated increase in our Medicare revenues of less than $1 million. Because of the uncertainty associated with various factors that may influence our future IRF payments, including legislative action, admission volumes, length of stay and case mix, and the impact of compliance with admission criteria, we cannot provide any assurances regarding our estimate of the impact of these changes.

Payment and Policy Changes to the Medicare Outpatient Prospective Payment System

On November 27, 2013, CMS released the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rules for the calendar year 2014 ("Final OPPS Rule"). The Final OPPS Rule includes the following payment and policy changes:

- A net update to OPPS payments equal to 1.7% resulting from the estimated market basket of 2.5%, minus an estimated productivity adjustment of 0.5% and a market basket reduction of 0.3%, both of which are required under certain provisions of the Affordable Care Act;

- The discontinuation of multiple codes for hospital clinic departments and conversion to single codes for those services; and

- An increase in the number of items and services that are packaged into the OPPS Ambulatory Payment Classification payments.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS Rule will yield an average 1.9% increase in payments for all hospitals and an average 2.0% increase in payments for hospitals in large urban areas (populations over one million). According to CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS Rule on the hospitals we owned on December 31, 2013 is an $27 million increase in Medicare outpatient revenues. Because of the uncertainty associated with the proposals, and other factors that may influence our future

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OPPS payments by individual hospital, including legislative action, patient volumes and case mix, we cannot provide any assurances regarding this estimate.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On November 27, 2013, CMS released the final update to the Medicare Physician Fee Schedule ("MPFS") for calendar year 2014. The MPFS is the schedule of rates Medicare pays for physician and other professional services and is updated annually. The MPFS update is determined by the "sustainable growth rate" ("SGR") formula in accordance with the Balanced Budget Act of 1997. CMS estimates that the calendar year 2014 update to the MPFS would result in a reduction to payments of approximately 20.1%. For the past 10 years, negative adjustments to the MPFS resulting from the SGR formula have been overridden by Congress. Because of budget neutrality requirements, these overrides have been funded in part with reductions to hospital and other provider payments. On December 26, 2013, the President signed into law House Joint Resolution 59, also known as the Bipartisan Budget Act of 2013 and the Pathway for SGR Reform Act of 2013. The resolution averts the 20.1% reduction and replaces it with a 0.5% increase to the conversion factor for the MPFS through March 31, 2014.

Although the historical pattern suggests that Congress will override the SGR formula reduction for the remainder of 2014, we cannot provide any assurances in that regard. Because a temporary or permanent change to the SGR formula would likely involve payment reductions to other providers (including hospitals), we cannot predict what impact such changes would have on our future net revenues or cash flows.

Medicare Claims Reviews

HHS estimates that approximately 10.1% of all Medicare Fee-For-Service ("FFS") claim payments in FFY 2013 were improper. The Improper Payments Information Act of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010, requires the heads of federal agencies, including HHS, to annually review programs it administers to:

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments in those programs;
- Submit those estimates to Congress; and
- Describe the actions the agency is taking to reduce improper payments in those programs.

CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. As a result, in addition to the Recovery Audit Contractor ("RAC") program, which currently performs post-payment claims reviews, CMS has recently established initiatives to prevent improper payments before a claim is processed. These initiatives include a significant increase in the number of prepayment claims reviews performed by MACs.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment claims denials are subject to administrative and judicial review. We have established robust protocols to respond to claims reviews and payment denials. Payment recoveries resulting from MAC reviews can be appealed through administrative and judicial processes, and we intend to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

Affordable Care Act

The ACA is changing how health care services in the United States are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth and other reductions in Medicare program spending, and the establishment of programs where reimbursement is tied to quality and integration. In addition, the law reforms certain aspects of

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health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. The expansion of health insurance coverage under the ACA may result in a material increase in the number of patients using our facilities who have either private or public program coverage. On the other hand, the ACA provides for significant reductions in Medicare market basket updates and decreases in Medicare and Medicaid DSH payments. Given that approximately 31% of our net patient revenues before provision for doubtful accounts in 2013 were from Medicare and Medicaid, reductions to these programs may significantly impact us and could offset any positive effects of the ACA.

In addition to increasing funding for the CMS Medicaid Integrity Program, which employs Medicaid Integrity Contractors to audit Medicaid claims, the ACA expanded the RAC program's scope to include Medicare Advantage plans and Medicaid claims beginning in 2012. We cannot predict with certainty the impact of these programs on our future results of operations or cash flows.

As described in greater detail under Item 1, Business — Health Care Regulation and Licensing, of Part I of this report, there is significant uncertainty with respect to the positive and negative effects the ACA may have on reimbursement, utilization and the future design of provider networks and insurance plans (including pricing, provider participation, coverage, co-pays and deductibles), and the multiple models that attempt to predict those effects may differ materially from our expectations. Because of the many variables involved, we are unable to predict the ultimate net effect on our future revenues and operations of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us.

The American Recovery and Reinvestment Act of 2009

The ARRA was enacted to stimulate the U.S. economy. One provision of ARRA provides financial incentives to hospitals and physicians to become "meaningful users" of electronic health records. The Medicare incentive payments to individual hospitals are made over a four-year, front-weighted transition period. The Medicaid incentive payments, which are administered by the states, are subject to more flexible payment and compliance standards than Medicare incentive payments; hospitals that achieve compliance between 2014 and 2015 will receive reduced incentive payments during the transition period.

We anticipate that we will incur selected operating expenses related to our overall HIT program of approximately $145 million in 2014 compared to approximately $105 million of Medicare and Medicaid EHR incentive payments we expect to recognize. In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Hospitals that fail to become meaningful users of EHRs or fail to submit quality data by 2015 will be subject to penalties in the form of a reduction to Medicare payments. This reduction, which will be based on the market basket update, will be phased in over three years and will continue until a hospital achieves compliance. Should all of our hospitals, including those acquired as part of the Vanguard acquisition, fail to become meaningful users of EHRs and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of approximately $15 million, $35 million and $55 million in 2015, 2016, and 2017 and subsequent years, respectively.

During the year ended December 31, 2013, we recognized approximately $96 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of 54 of our hospitals and certain of our employed physicians demonstrating meaningful use of certified EHR technology. These incentives partially offset approximately $117 million of selected operating expenses we incurred in 2013 related to our overall HIT program. The final Medicare EHR incentive payments are determined when the cost report that begins in the federal fiscal year during which the hospital achieved meaningful use is settled. Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

The complexity of the changes required to our hospitals' systems and the time required to complete the changes will likely result in some or all of our hospitals not being fully compliant in time to be eligible for the maximum HIT funding permitted under ARRA. Because of the uncertainties regarding the implementation of HIT, including CMS' future EHR implementation regulations, the ability of our hospitals to achieve compliance and the associated costs, we cannot provide any assurances regarding the aforementioned estimates.

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The American Taxpayer Relief Act of 2012

The American Taxpayer Relief Act of 2012 delayed by two months the effective date of the automatic reductions (referred to as "sequestration") in federal spending, including a 2% reduction in Medicare payments, mandated by the Budget Control Act of 2011 that was originally scheduled to take effect on February 1, 2013. On March 1, 2013, the President signed an order to begin the sequestration. Effective April 1, 2013, all Medicare payments to providers began to be reduced by 2% and will continue to be paid at the reduced rate as long as the sequestration is in effect. As of December 31, 2013, Congress had not taken any action to reduce or eliminate the sequestration adjustment. Any such action would likely require other payments reductions in order to maintain budget neutrality. We cannot predict how long the sequestration will be in effect, nor can we predict what Medicare payment, eligibility and coverage changes, if any, will be enacted in lieu of the sequestration.

The Continuing Appropriations and Consolidated Appropriations Acts of 2014

On October 17, 2013, the President signed the Continuing Appropriations Act, 2014 into law, which provided FFY 2014 appropriations for projects and activities of the federal government at sequestration levels through January 15, 2014 and extended the U.S. debt limit through February 7, 2014. The law also included provisions intended to strengthen eligibility verification of those who apply for insurance subsidies under the Affordable Care Act. On January 17, 2014, the President signed the Consolidated Appropriations Act of 2014 into law, which continues appropriations for FFY 2014, but does not provide any new funding for the ACA. We cannot predict what further actions Congress or the President may take with respect to appropriations or the debt limit or the effect, if any, of such actions on our net revenues or cash flows.

The Bipartisan Budget Act of 2013

As described above, the Bipartisan Budget Act of 2013 averted a 20.1% reduction to payments under the MPFS and replaced it with a 0.5% increase for the period January 1, 2014 through March 31, 2014. Other significant Medicare and Medicaid provisions of the Bipartisan Budget Act included:

- A delay in the reductions to Medicaid DSH allotments to states required under the ACA until FFY 2016 (the reductions were originally scheduled to begin in FFY 2014);
- A continuation of the Medicare sequestration reductions through the remainder of FFY 2014; and
- An extension of the sequestration for mandatory programs, including Medicare, for another two years through 2023.

MedPAC FFY 2014 Recommendations

Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems. Generally, the MedPAC opposes sequestration as a way to reduce payments, particularly below the base rate, because the MedPAC favors a more targeted approach to achieve savings. In January 2014, the MedPAC voted in favor of three recommendations for hospital inpatient and outpatient services, two of which affect acute care hospitals. Specifically, the MedPAC voted that Congress should direct HHS to:

- Reduce or eliminate the differences in payment rates between outpatient departments and physicians' offices for selected APCs; and
- Increase payment rates for the IPPS and OPPS in FFY 2015 by 3.25%.

We expect these recommendations to be included in the forthcoming MedPAC Annual Report to Congress. Congress is not obligated to adopt the MedPAC recommendations and, based on outcomes in previous years, there can be no assurance Congress will adopt such recommendations in a given year. We cannot predict what actions, if any, Congress, HHS or CMS will take with respect to the MedPAC recommendations or the effect, if any, of such actions on our net revenues or cash flows.

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Extension of Medicare Sequestration

In February 2014, the President signed into law legislation that includes the restoration of certain military pension benefits and extension of the Medicare sequestration payment reductions for an additional year through FFY 2014.

PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service health care delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate health care can be efficiently delivered in the most cost-effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted health care providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted health care providers. PPO members who use contracted health care providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible health care plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient revenues during the years ended December 31, 2013, 2012 and 2011 was $6.3 billion, $5.4 billion and $5.1 billion, respectively. Approximately 59% of our managed care net patient revenues for the year ended December 31, 2013 was derived from our top ten managed care payers. Approximately 44% of the total net managed care revenues of our same-hospitals owned for at least one year was generated from national payers. The remainder comes from regional or local payers. At December 31, 2013 and 2012 approximately 58% and 52%, respectively, of our net accounts receivable related to continuing operations were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of December 31, 2013, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $13 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have had improved year-over-year managed care pricing, we expect some moderation in the pricing percentage increases in future years. It is not clear what impact, if any, the increased obligations on managed care and other payers imposed by the Affordable Care

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Act will have on our commercial managed care volumes and payment rates. In the year ended December 31, 2013, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

An indemnity-based agreement generally requires the insurer to reimburse an insured patient for health care expenses after those expenses have been incurred by the patient, subject to policy conditions and exclusions. Unlike an HMO member, a patient with indemnity insurance is free to control his or her utilization of health care and selection of health care providers.

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant portion of our self-pay patients is admitted through our hospitals' emergency departments and often requires high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe that our level of self-pay patients has been higher in the last several years than previous periods due to a combination of broad economic factors, including increased unemployment rates, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-pays and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectability problems. At both December 31, 2013 and 2012, approximately 7% of our net accounts receivable related to continuing operations were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have been increasing our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

Over the longer term, several other initiatives we have previously announced should also help address this challenge. For example, our *Compact with Uninsured Patients* ("Compact") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically have been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

Under the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), a new Consumer Financial Protection Bureau ("CFPB") was formed within the U.S. Federal Reserve to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. We believe that the CFPB regulatory and enforcement processes will have a significant impact on Conifer's operations. For additional information, see Item 1, Business — Regulations Affecting Conifer, of Part I of this report.

Our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the years ended December 31, 2013, 2012 and 2011 were approximately $545 million, $430 million and $379 million, respectively. We also provide charity care to patients who are financially unable to pay for the health care services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the years ended December 31, 2013, 2012

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and 2011 were approximately $428 million, $283 million and $255 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the years ended December 31, 2013, 2012 and 2011 were $158 million, $136 million and $113 million, respectively. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues.

The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either health insurance exchange or government health care insurance program coverage. However, because of the many variables involved, we are unable to predict with certainty the net impact on us of the expected increase in revenues and expected decrease in bad debt expense from providing care to previously uninsured and underinsured individuals, and numerous other provisions in the law that may affect us. In addition, even after implementation of the Affordable Care Act, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage under the Affordable Care Act and for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government health care insurance program.

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2013 COMPARED TO THE YEAR ENDED DECEMBER 31, 2012

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2013 and 2012:

	Years Ended December 31,		
	2013	2012	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 10,888	$ 9,436	$ 1,452
Other operations	1,186	468	718
Net operating revenues before provision for doubtful accounts	12,074	9,904	2,170
Less provision for doubtful accounts	972	785	187
Net operating revenues	**11,102**	**9,119**	**1,983**
Operating expenses:			
Salaries, wages and benefits	5,371	4,257	1,114
Supplies	1,784	1,552	232
Other operating expenses, net	2,701	2,147	554
Electronic health record incentives	(96)	(40)	(56)
Depreciation and amortization	545	430	115
Impairment of long-lived assets and goodwill, and restructuring charges	103	19	84
Litigation and investigation costs	31	5	26
Operating income	**$ 663**	**$ 749**	**$ (86)**

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	Years Ended December 31,		
	2013	2012	Increase (Decrease)
Net operating revenues	100.0%	100.0%	—%
Operating expenses:			
Salaries, wages and benefits	48.4%	46.7%	1.7%
Supplies	16.1%	17.0%	(0.9)%
Other operating expenses, net	24.3%	23.5%	0.8%
Electronic health record incentives	(0.9)%	(0.4)%	(0.5)%
Depreciation and amortization	4.9%	4.7%	0.2%
Impairment of long-lived assets and goodwill, and restructuring charges	0.9%	0.2%	0.7%
Litigation and investigation costs	0.3%	0.1%	0.2%
Operating income	**6.0%**	**8.2%**	**(2.2)%**

Net operating revenues of our general hospitals include inpatient and outpatient revenues, as well as nonpatient revenues (rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) services provided by our Conifer subsidiary to third parties and (4) our recently acquired health plans. Revenues from our general hospitals represented approximately 90% and 95% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2013 and 2012, respectively.

Net operating revenues from our other operations were $1.186 billion and $468 million in the years ended December 31, 2013 and 2012, respectively. The increase in net operating revenues from other operations during 2013 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our recently acquired health plans and additional physician practices. Equity earnings for unconsolidated affiliates included in our net operating revenues from other operations were $15 million and $8 million for each of the years ended December 31, 2013 and 2012, respectively. Included in 2013 equity earnings of unconsolidated affiliates is $10 million of earnings associated with stepping up our basis in a previously held investment in an ambulatory surgery center in which we acquired a controlling interest and are now consolidating.

Selected Operating Statistics for All Continuing Operations Hospitals —The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the statistics from the 28 hospitals we acquired from Vanguard on October 1, 2013.

	Total Hospital Continuing Operations		
	Years Ended December 31,		
	2013	2012	Increase (Decrease)
Total admissions	558,726	506,485	10.3%
Adjusted patient admissions(1)	915,276	796,520	14.9%
Surgeries – inpatient	155,634	141,288	9.9%
Surgeries – outpatient	334,233	239,667	39.5%
Total surgeries	489,867	380,955	28.6%
Patient days – total	2,621,245	2,368,916	10.7%
Adjusted patient days(1)	4,243,334	3,693,218	14.9%
Average length of stay (days)	4.69	4.68	0.2%
Average licensed beds	14,963	13,187	13.5%
Utilization of licensed beds(3)	48.0%	49.1%	(1.1)%(2)
Total outpatient visits	5,074,606	4,167,114	21.8%
Net inpatient revenues	$ 6,952	$ 6,200	12.1%
Net outpatient revenues	$ 3,859	$ 3,167	21.9%
Net inpatient revenue per admission	$ 12,443	$ 12,241	1.7%
Net inpatient revenue per patient day	$ 2,652	$ 2,617	1.3%
Net outpatient revenue per visit	$ 760	$ 760	—%
Net patient revenue per adjusted admission	$ 11,812	$ 11,760	0.4%

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The tables below show certain selected historical operating statistics of our continuing hospitals on a same-hospital basis, where noted, and exclude the results of our acquisition of Vanguard effective October 1, 2013 because it has not been owned for more than one calendar year.

	Same-Hospital Continuing Operations Years Ended December 31,		
Admissions, Patient Days and Surgeries	**2013**	**2012**	**Increase (Decrease)**
Total admissions	490,624	506,485	(3.1)%
Adjusted patient admissions(1)	787,995	796,520	(1.1)%
Paying admissions (excludes charity and uninsured)	455,550	470,756	(3.2)%
Charity and uninsured admissions	35,074	35,729	(1.8)%
Admissions through emergency department	308,200	312,902	(1.5)%
Paying admissions as a percentage of total admissions	92.9%	92.9%	—%(2)
Charity and uninsured admissions as a percentage of total admissions	7.1%	7.1%	—%(2)
Emergency department admissions as a percentage of total admissions	62.8%	61.8%	1.0%(2)
Surgeries – inpatient	136,713	141,288	(3.2)%
Surgeries – outpatient	303,500	239,667	26.6%
Total surgeries	440,213	380,955	15.6%
Patient days – total	2,315,304	2,368,916	(2.3)%
Adjusted patient days(1)	3,683,018	3,693,218	(0.3)%
Average length of stay (days)	4.72	4.68	0.9%
Number of hospitals (at end of period)	49	49	—(2)
Licensed beds (at end of period)	13,178	13,216	(0.3)%
Average licensed beds	13,180	13,187	(0.1)%
Utilization of licensed beds(3)	48.1%	49.1%	(1.0)%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the 2013 and 2012 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

	Same-Hospital Continuing Operations Years Ended December 31,		
Outpatient Visits	**2013**	**2012**	**Increase (Decrease)**
Total visits	4,287,116	4,167,114	2.9%
Paying visits (excludes charity and uninsured)	3,834,195	3,728,402	2.8%
Charity and uninsured visits	452,921	438,712	3.2%
Emergency department visits	1,607,075	1,555,102	3.3%
Surgery visits	303,500	239,667	26.6%
Paying visits as a percentage of total visits	89.4%	89.5%	(0.1)%(1)
Charity and uninsured visits as a percentage of total visits	10.6%	10.5%	0.1%(1)

(1) The change is the difference between the 2013 and 2012 amounts shown.

	Same-Hospital Continuing Operations Years Ended December 31,		
Revenues	**2013**	**2012**	**Increase (Decrease)**
Net operating revenues	$ 9,688	$ 9,119	6.2%
Revenues from the uninsured	$ 671	$ 636	5.5%
Net inpatient revenues(1)	$ 6,101	$ 6,200	(1.6)%
Net outpatient revenues(1)	$ 3,366	$ 3,167	6.3%

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $279 million and $269 million for the years ended December 31, 2013 and 2012, respectively. Net outpatient revenues include self-pay revenues of $392 million and $367 million for the years ended December 31, 2013 and 2012, respectively.

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Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2013	2012	Increase (Decrease)
Net inpatient revenue per admission	$ 12,435	$ 12,241	1.6%
Net inpatient revenue per patient day	$ 2,635	$ 2,617	0.7%
Net outpatient revenue per visit	$ 785	$ 760	3.3%
Net patient revenue per adjusted patient admission(1)	$ 12,014	$ 11,760	2.2%
Net patient revenue per adjusted patient day(1)	$ 2,570	$ 2,536	1.3%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2013	2012	Increase (Decrease)
Provision for doubtful accounts	$ 829	$ 785	5.6%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.9%	7.9%	—%(1)
Collection rate on self-pay accounts(2)	28.7%	28.9%	(0.2)%(1)
Collection rate on commercial managed care accounts	98.3%	98.0%	0.3%(1)

(1) The change is the difference between the 2013 and 2012 amounts shown.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

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Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2013	2012	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 4,142	$ 3,983	4.0%
Supplies	1,555	1,552	0.2%
Other operating expenses	2,093	2,040	2.6%
Total	$ 7,790	$ 7,575	2.8%
Conifer			
Salaries, wages and benefits	$ 576	$ 274	110.2%
Other operating expenses	211	107	97.2%
Total	$ 787	$ 381	106.6%
Total			
Salaries, wages and benefits	$ 4,718	$ 4,257	10.8%
Supplies	1,555	1,552	0.2%
Other operating expenses	2,304	2,147	7.3%
Total	$ 8,577	$ 7,956	7.8%
Rent/lease expense(1)			
Hospital Operations and other	$ 153	$ 144	6.3%
Conifer	14	12	16.7%
Total	$ 167	$ 156	7.1%
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,124	$ 1,078	4.3%
Supplies per adjusted patient day	422	420	0.5%
Other operating expenses per adjusted patient day	561	553	1.4%
Total per adjusted patient day	$ 2,107	$ 2,051	2.7%
Salaries, wages and benefits per adjusted patient admission	$ 5,253	$ 5,001	5.0%
Supplies per adjusted patient admission	1,973	1,948	1.3%
Other operating expenses per adjusted patient admission	2,622	2,561	2.4%
Total per adjusted patient admission	$ 9,848	$ 9,510	3.6%

(1) Included in other operating expenses.

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

REVENUES

During the year ended December 31, 2013, same-hospital net operating revenues before provision for doubtful accounts increased 6.2%, compared to the year ended December 31, 2012, primarily due to improved terms of our managed care contracts, an increase in outpatient volumes and an increase in our other operations revenues, partially offset by a decrease in inpatient volumes and the impact of a $81 million favorable adjustment in the 2012 period from the industry-wide settlement (the "Medicare Budget Neutrality settlement") that corrected Medicare payments made to providers for inpatient hospital services for a number of prior periods.

Our same-hospital net outpatient revenues and total outpatient visits increased 6.3% and 2.9%, respectively, during the year ended December, 31 2013 compared to the year ended December 31, 2012. Outpatient revenues and volume growth was primarily driven by improved terms of our managed care contracts, increased outpatient volume levels and our outpatient acquisition program. Net outpatient revenue per visit increased 3.3% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $919 million and $488 million for the year ended December 31, 2013 and 2012, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to the 10-year CHI agreement entered into in May 2012, expanded service offerings and two acquisitions in the three months ended December 31, 2012.

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Same-hospital patient days decreased by 2.3% during the year ended December 31, 2013 compared to the year ended December 31, 2012. We believe the following factors contributed to the changes in our inpatient volume levels: (1) the current weak economic conditions, which we believe have adversely impacted the level of elective procedures performed at our hospitals; (2) loss of patients to competing health care providers; (3) an increase in patients with high-deductible health insurance plans; and (4) industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than in an inpatient setting.

PROVISION FOR DOUBTFUL ACCOUNTS

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.1% for the year ended December 31, 2013 compared to 7.9% for the year ended December 31, 2012. The 5.6% increase in the absolute amount of provision for doubtful accounts in the 2013 period compared to the 2012 period was primarily due to a 5.5% increase in uninsured patient revenues, as well as higher patient co-pays and deductibles for our same-hospitals. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2013 and December 31, 2012:

	December 31, 2013			December 31, 2012		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 309	$ —	$ 309	$ 172	$ —	$ 172
Medicaid	141	—	141	116	—	116
Net cost report settlements payable and valuation allowances	(4)	—	(4)	(24)	—	(24)
Managed care	1,240	69	1,171	769	72	697
Self-pay uninsured	344	290	54	204	178	26
Self-pay balance after insurance	224	141	83	143	78	65
Estimated future recoveries from accounts assigned to our Conifer subsidiary	91	—	91	88	—	88
Other payers	279	89	190	264	68	196
Total continuing operations	2,624	589	2,035	1,732	396	1,336
Total discontinued operations	3	—	3	14	5	9
	$ 2,627	**$ 589**	**$ 2,038**	**$ 1,746**	**$ 401**	**$ 1,345**

We provide revenue cycle management and patient communications services, among others, through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have increased our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology, and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years, as we have experienced adverse changes in our business mix. At December 31, 2013, our same-hospital collection rate on self-pay accounts was approximately 28.7%. Our recent same-hospital self-pay collection rates were as follows: 27.9% at March 31, 2012; 28.5% at June 30, 2012; 28.8% at September 30, 2012; 28.9% at December 31, 2012; 28.8% at March 31, 2013; 28.7% at June 30, 2013; and 28.8% at September 30, 2013. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2013, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million.

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Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated same-hospital collection rate from managed care payers was approximately 98.3% at December 31, 2013 and 98.0% at December 31, 2012.

Conifer continues to focus on revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collection at point-of-service, and financial counseling. The goals of the effort are focused on reducing denials, improving service levels to patients and increasing the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) accounts receivable days outstanding ("AR Days"), and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from continuing operations of $2.039 billion and $1.360 billion at December 31, 2013 and 2012, respectively, excluding cost report settlements payable and valuation allowances of $4 million and $24 million at December 31, 2013 and 2012, respectively:

	December 31, 2013				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	76%	58%	73%	32%	65%
61-120 days	9%	21%	13%	17%	14%
121-180 days	4%	9%	5%	7%	6%
Over 180 days	11%	12%	9%	44%	15%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

	December 31, 2012				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	92%	62%	78%	29%	67%
61-120 days	2%	19%	11%	17%	12%
121-180 days	1%	8%	4%	9%	5%
Over 180 days	5%	11%	7%	45%	16%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Our AR Days from continuing operations were 48.3 days at December 31, 2013 and 52.7 days at December 31, 2012, respectively, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2013, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $3.3 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medical Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. At the present time our new acquisitions are not part of this program. Based on recent trends, approximately 93% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts

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receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2013 and 2012 by aging category:

	December 31, 2013	December 31, 2012
0-60 days	$ 132	$ 99
61-120 days	28	22
121-180 days	8	5
Over 180 days	18	16
Total	**$ 186**	**$ 142**

SALARIES, WAGES AND BENEFITS

Salaries, wages and benefits expense as a percentage of net operating revenues increased 1.7% for the year ended December 31, 2013 compared to the year ended December 31, 2012. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 5.0% in the year ended December 31, 2013 compared to the same period in 2012. This increase is primarily due to an increase in the number of physicians we employ, annual merit increases for certain of our employees, increased health benefits costs and increased contract labor, partially offset by a decrease in incentive compensation expense. Salaries, wages and benefits expense for the year ended December 31, 2013 and 2012 included stock-based compensation expense of $37 million and $32 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $302 million in the year ended December 31, 2013 compared to the year ended December 31, 2012 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the new CHI partnership, the Vanguard acquisition and Conifer's two acquisitions in the three months ended December 31, 2012.

As of December 31, 2013, approximately 21% of our employees were represented by various labor unions. These employees — primarily registered nurses and service and maintenance workers — were located at 39 of our hospitals, the majority of which are in California, Florida, Massachusetts and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating an initial contract at one of our hospitals where employees recently chose union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014.

SUPPLIES

Supplies expense as a percentage of net operating revenues decreased 0.9% for the year ended December 31, 2013 compared to the year ended December 31, 2012. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 1.3% in the year ended December 31, 2013 compared to the same period in 2012. Supplies expense was favorably impacted by lower implant costs, orthopedic supply costs and cardiology supply costs due to renegotiated prices, partially offset by increased costs of pharmaceuticals and increased surgical supply costs as a result of higher surgical volumes.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, bulk purchases and operational improvements. The items of current cost reduction focus continue to be cardiac stents and pacemakers, orthopedics and implants, and high-cost pharmaceuticals. We also utilize group-purchasing strategies and supplies-management services in an effort to reduce costs.

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OTHER OPERATING EXPENSES, NET

Other operating expenses as a percentage of net operating revenues was 24.3% in the year ended December 31, 2013 compared to 23.5% in the year ended December 31, 2012. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 2.4% in the year ended December 31, 2013 compared to the same period in 2012. The 2.6% increase in same-hospital other operating expenses in the year ended December 31, 2013 compared to the year ended December 31, 2012 is primarily due to:

- increased costs of contracted services ($92 million) primarily related to Conifer's new clients and business acquisitions;
- increased medical fees primarily related to employed physicians ($42 million);
- increased rent and lease expenses ($6 million); and
- increased malpractice expense ($6 million).

These increases were partially offset by lower consulting and legal expenses ($25 million) in part due to the aforementioned Medicare Budget Neutrality settlement in 2012.

Malpractice expense in the year ended December 31, 2013 included favorable adjustments totaling approximately $11 million due to a 127 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of $2 million due to a 17 basis point decrease in the interest rate in the 2012 period.

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment continues to decline. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination costs, and $59 million in acquisition-related costs, which includes both transaction costs and acquisition integration charges.

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of $19 million, consisting of $3 million relating to the impairment of obsolete assets, $2 million relating to other impairment charges, $8 million of employee severance costs and $6 million of other related costs.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges.

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LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the year ended December 31, 2013 and 2012 were $31 million and $5 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2013 was $474 million compared to $412 million for the year ended December 31, 2012, primarily due to increased borrowings partially offset by a lower average interest rate on our outstanding debt.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2013, we recorded a loss from early extinguishment of debt of $348 million consisting of $177 million related to the difference between the purchase prices and the par values of the $714 million aggregate principal amount of our 10% senior secured notes due 2018 that we purchased and called during the period, as well as the write-off of unamortized note discounts and issuance costs, and $171 million related to the difference between the purchase prices and the par values of the $925 million aggregate principal amount of our 8 $^{7}/_{8}$% senior secured notes due 2019 that we purchased and called during the period, as well as the write-off of unamortized note discounts and issuance costs.

INCOME TAX EXPENSE

During the year ended December 31, 2013, we recorded an income tax benefit of $65 million, primarily related to the loss from early extinguishment of debt, compared to an expense of $125 million during the year ended December 31, 2012.

DISCONTINUED OPERATIONS: IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL, AND RESTRUCTURING CHARGES

During the year ended December 31, 2012, we recorded an impairment charge in discontinued operations of $100 million related to the sale of Creighton University Medical Center, consisting of $98 million for the write-down of long-lived assets to their estimated fair values and a $2 million charge for the write-down of goodwill.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

The financial information provided throughout this report, including our Condensed Consolidated Financial Statements and the notes thereto, has been prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). However, we use certain non-GAAP financial measures defined below in communications with investors, analysts, rating agencies, banks and others to assist such parties in understanding the impact of various items on our financial statements, some of which are recurring or involve cash payments. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure that we use in our analysis of the performance of our business, which we define as net income (loss) attributable to our common shareholders before: (1) the cumulative effect of changes in accounting principle, net of tax; (2) net loss (income) attributable to noncontrolling interests; (3) preferred stock dividends; (4) income (loss) from discontinued operations, net of tax; (5) income tax benefit (expense); (6) investment earnings (loss); (7) gain (loss) from early extinguishment of debt; (8) net gain (loss) on sales of investments; (9) interest expense; (10) litigation and investigation benefit (costs), net of insurance recoveries; (11) hurricane insurance recoveries, net of costs; (12) impairment and restructuring charges and acquisition-related costs; and (13) depreciation and amortization. As is the case with all non-GAAP measures, investors should consider the limitations associated with this metric, including the potential lack of comparability of this measure from one company to another, and should recognize that Adjusted EBITDA does not provide a complete measure of our operating performance because it excludes many items that are included in our financial statements. Accordingly, investors are encouraged to use GAAP measures when evaluating our financial performance.

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The table below shows the reconciliation of Adjusted EBITDA to net income attributable to our common shareholders (the most comparable GAAP term) for the years ended December 31, 2013 and 2012:

	Years Ended December 31,	
	2013	2012
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ (134)	$ 141
Less: Net loss (income) attributable to noncontrolling interests	(30)	19
Preferred stock dividends	—	(11)
Loss from discontinued operations, net of tax	(11)	(76)
Income (loss) from continuing operations	(93)	209
Income tax benefit (expense)	65	(125)
Investment earnings	1	1
Loss from early extinguishment of debt	(348)	(4)
Interest expense	(474)	(412)
Operating income	663	749
Litigation and investigation costs	(31)	(5)
Impairment and restructuring charges, and acquisition-related costs	(103)	(19)
Depreciation and amortization	(545)	(430)
Adjusted EBITDA	**$ 1,342**	**$ 1,203**
Net operating revenues	**$ 11,102**	**$ 9,119**
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	**12.1%**	**13.2%**

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2012 COMPARED TO THE YEAR ENDED DECEMBER 31, 2011

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2012 and 2011:

	Years Ended December 31,		
	2012	2011	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 9,436	$ 9,061	$ 375
Other operations	468	310	158
Net operating revenues before provision for doubtful accounts	9,904	9,371	533
Less provision for doubtful accounts	785	717	68
Net operating revenues	**9,119**	**8,654**	**465**
Operating expenses:			
Salaries, wages and benefits	4,257	4,015	242
Supplies	1,552	1,548	4
Other operating expenses, net	2,147	2,020	127
Electronic health record incentives	(40)	(55)	15
Depreciation and amortization	430	398	32
Impairment of long-lived assets and goodwill, and restructuring charges	19	20	(1)
Litigation and investigation costs	5	55	(50)
Operating income	**$ 749**	**$ 653**	**$ 96**

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	Years Ended December 31,		
	2012	2011	Increase (Decrease)
Net operating revenues	100.0%	100.0%	—%
Operating expenses:			
Salaries, wages and benefits	46.7%	46.4%	0.3%
Supplies	17.0%	17.9%	(0.9)%
Other operating expenses, net	23.5%	23.4%	0.1%
Electronic health record incentives	(0.4)%	(0.6)%	0.2%
Depreciation and amortization	4.7%	4.6%	0.1%
Impairment of long-lived assets and goodwill, and restructuring charges	0.2%	0.2%	—%
Litigation and investigation costs	0.1%	0.6%	(0.5)%
Operating income	**8.2%**	**7.5%**	**0.7%**

Revenues from our general hospitals represented approximately 95% and 97% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2012 and 2011, respectively.

Net operating revenues from our other operations were $468 million and $310 million in the years ended December 31, 2012 and 2011, respectively. The increase in net operating revenues from other operations during 2012 primarily relates to our additional owned physician practices and revenue cycle services provided by our Conifer subsidiary. Equity earnings for unconsolidated affiliates included in our net operating revenues from other operations were $8 million for each of the years ended December 31, 2012 and 2011.

The tables below show certain selected historical operating statistics of our continuing hospitals on a same-hospital basis. We have excluded statistics related to hospitals previously owned by Vanguard from the same-hospital statistics for the years ended December 31, 2012 and 2011 because we did not own those hospitals during those years.

	Same-Hospital Continuing Operations Years Ended December 31,		
Admissions, Patient Days and Surgeries	2012	2011	Increase (Decrease)
Total admissions	506,485	507,834	(0.3)%
Adjusted patient admissions(1)	796,520	779,833	2.1%
Paying admissions (excludes charity and uninsured)	470,756	473,943	(0.7)%
Charity and uninsured admissions	35,729	33,891	5.4%
Admissions through emergency department	312,902	306,424	2.1%
Paying admissions as a percentage of total admissions	92.9%	93.3%	(0.4)%(2)
Charity and uninsured admissions as a percentage of total admissions	7.1%	6.7%	0.4%(2)
Emergency department admissions as a percentage of total admissions	61.8%	60.3%	1.5%(2)
Surgeries – inpatient	141,288	144,665	(2.3)%
Surgeries – outpatient	239,667	217,621	10.1%
Total surgeries	380,955	362,286	5.2%
Patient days – total	2,368,916	2,413,245	(1.8)%
Adjusted patient days(1)	3,693,218	3,673,441	0.5%
Average length of stay (days)	4.68	4.75	(1.5)%
Number of hospitals (at end of period)	49	49	—(2)
Licensed beds (at end of period)	13,216	13,119	0.7%
Average licensed beds	13,187	13,115	0.5%
Utilization of licensed beds(3)	49.1%	50.4%	(1.3)%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the 2012 and 2011 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

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Outpatient Visits	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Total visits	4,167,114	3,954,016	5.4%
Paying visits (excludes charity and uninsured)	3,728,402	3,554,231	4.9%
Charity and uninsured visits	438,712	399,785	9.7%
Emergency department visits	1,555,102	1,457,250	6.7%
Surgery visits	239,667	217,621	10.1%
Paying visits as a percentage of total visits	89.5%	89.9%	(0.4)%(1)
Charity and uninsured visits as a percentage of total visits	10.5%	10.1%	0.4%(1)

(2) The change is the difference between the 2012 and 2011 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Net operating revenues	$ 9,119	$ 8,654	5.4%
Revenues from the uninsured	$ 636	$ 607	4.8%
Net inpatient revenues(1)	$ 6,200	$ 6,028	2.9%
Net outpatient revenues(1)	$ 3,167	$ 2,928	8.2%

(2) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $269 million and $271 million for the years ended December 31, 2012 and 2011, respectively. Net outpatient revenues include self-pay revenues of $367 million and $336 million for the years ended December 31, 2012 and 2011, respectively.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Net inpatient revenue per admission	$ 12,241	$ 11,870	3.1%
Net inpatient revenue per patient day	$ 2,617	$ 2,498	4.8%
Net outpatient revenue per visit	$ 760	$ 741	2.6%
Net patient revenue per adjusted patient admission(1)	$ 11,760	$ 11,485	2.4%
Net patient revenue per adjusted patient day(1)	$ 2,536	$ 2,438	4.0%

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Provision for doubtful accounts	$ 785	$ 717	9.5%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.9%	7.7%	0.2%(1)
Collection rate on self-pay accounts(2)	28.9%	27.7%	1.2%(1)
Collection rate on commercial managed care accounts	98.0%	98.2%	(0.2)%(1)

(1) The change is the difference between the 2012 and 2011 amounts shown.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

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Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 3,983	$ 3,792	5.0%
Supplies	1,552	1,548	0.3%
Other operating expenses	2,040	1,946	4.8%
Total	$ 7,575	$ 7,286	4.0%
Conifer			
Salaries, wages and benefits	$ 274	$ 223	22.9%
Other operating expenses	107	74	44.6%
Total	$ 381	$ 297	28.3%
Total			
Salaries, wages and benefits	$ 4,257	$ 4,015	6.0%
Supplies	1,552	1,548	0.3%
Other operating expenses	2,147	2,020	6.3%
Total	$ 7,956	$ 7,583	4.9%
Rent/lease expense(1)			
Hospital Operations and other	$ 144	$ 132	9.1%
Conifer	12	11	9.1%
Total	$ 156	$ 143	9.1%
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,078	$ 1,032	4.5%
Supplies per adjusted patient day	420	421	(0.2)%
Other operating expenses per adjusted patient day	553	530	4.3%
Total per adjusted patient day	$ 2,051	$ 1,983	3.4%
Salaries, wages and benefits per adjusted patient admission	$ 5,001	$ 4,863	2.8%
Supplies per adjusted patient admission	1,948	1,985	(1.9)%
Other operating expenses per adjusted patient admission	2,561	2,495	2.6%
Total per adjusted patient admission	$ 9,510	$ 9,343	1.8%

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

REVENUES

During the year ended December 31, 2012, net operating revenues before provision for doubtful accounts increased 5.7%, which included a 4.6% increase in net patient revenues, compared to the year ended December 31, 2011. Increases in pricing were the largest contributing factors, resulting in a 4.0% increase in net patient revenues, while increases in our overall volumes resulted in a 0.6% increase in net patient revenues.

Our same-hospital net inpatient revenues for the year ended December 31, 2012 increased by 2.9% compared to the year ended December, 31, 2011. Several factors impacted our net inpatient revenues in the 2012 period compared to the 2011 period, including:

- Improved managed care pricing as a result of renegotiated contracts;
- Medicaid DSH and other state-funded subsidy revenues of $283 million in the year ended December 31, 2012 compared to $255 million in the year ended December 31, 2011;
- Favorable adjustments of approximately $81 million in the year ended December 31, 2012 related to the aforementioned Medicare Budget Neutrality settlement; and
- An unfavorable shift in our total payer mix.

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Patient days decreased by 1.8% and total admissions decreased by 0.3% during the year ended December 31, 2012 compared to the year ended December 31, 2011. We believe the following factors contributed to the changes in our inpatient volume levels: (1) weak economic conditions, which we believe adversely impacted the level of elective procedures performed at our hospitals; (2) loss of patients to competing health care providers; and (3) industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than in an inpatient setting.

Same-hospital net outpatient revenues and total outpatient visits increased 8.2% and 5.4%, respectively, during the year ended December 31, 2012 compared to the year ended December 31, 2011. The growth in our outpatient revenues and volumes was related to both organic growth and growth from acquisitions. Net outpatient revenue per visit increased 2.6% primarily due to the improved terms of our managed care contracts, partially offset by the provision of lower acuity services by outpatient centers we acquired in the past several years, as well as an unfavorable shift in our total outpatient payer mix.

Our Conifer subsidiary generated net operating revenues of $488 million and $340 million for the years ended December 31, 2012 and 2011, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients, expanded service offerings and acquisitions.

PROVISION FOR DOUBTFUL ACCOUNTS

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.9% for the year ended December 31, 2012 compared to 7.7% for the year ended December 31, 2011. The increase in provision for doubtful accounts primarily related to increased uninsured patient volumes, partially offset by the impact of a 120 basis point improvement in our collection rate on self-pay accounts.

The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2012 and 2011:

	December 31, 2012			December 31, 2011		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 172	$ —	$ 172	$ 166	$ —	$ 166
Medicaid	116	—	116	118	—	118
Net cost report settlements payable and valuation allowances	(24)	—	(24)	(39)	—	(39)
Managed care	769	72	697	760	67	693
Self-pay uninsured	204	178	26	215	190	25
Self-pay balance after insurance	143	78	65	134	77	57
Estimated future recoveries from accounts assigned to our Conifer subsidiary	88	—	88	62	—	62
Other payers	264	68	196	212	48	164
Total continuing operations	1,732	396	1,336	1,628	382	1,246
Total discontinued operations	14	5	9	47	15	32
	$ 1,746	**$ 401**	**$ 1,345**	**$ 1,675**	**$ 397**	**$ 1,278**

At December 31, 2012, our collection rate on self-pay accounts was approximately 28.9%. We experienced a relatively stable self-pay collection rate during 2011 and 2012 as follows: 27.8% at March 31, 2011; 27.9% at June 30, 2011; 27.7% at both September 30, 2011 and December 31, 2011; 27.9% at March 31, 2012; 28.5% at June 30, 2012; and 28.8% at September 30, 2012. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2012, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $7 million.

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Our estimated collection rate from managed care payers was approximately 98.0% at December 31, 2012 and 98.2% at December 31, 2011.

The following tables present the approximate aging by payer of our net accounts receivable from continuing operations of $1.360 billion and $1.285 billion at December 31, 2012 and 2011, respectively, excluding cost report settlements payable and valuation allowances of $24 million and $39 million at December 31, 2012 and 2011, respectively:

	December 31, 2012				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	92%	62%	78%	29%	67%
61-120 days	2%	19%	11%	17%	12%
121-180 days	1%	8%	4%	9%	5%
Over 180 days	5%	11%	7%	45%	16%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

	December 31, 2011				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	93%	63%	75%	31%	68%
61-120 days	3%	18%	12%	17%	12%
121-180 days	2%	9%	5%	10%	6%
Over 180 days	2%	10%	8%	42%	14%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Our AR Days from continuing operations were 53 days at both December 31, 2012 and 2011, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2012, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $3.2 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2012 and 2011 by aging category:

	December 31,	
	2012	2011
0-60 days	$ 99	$ 82
61-120 days	22	18
121-180 days	5	7
Over 180 days	16	15
Total	**$ 142**	**$ 122**

SALARIES, WAGES AND BENEFITS

Salaries, wages and benefits expense as a percentage of net operating revenues increased 0.3% for the year ended December 31, 2012 compared to the year ended December 31, 2011. Salaries, wages and benefits per adjusted patient admission increased 2.8% in the year ended December 31, 2012 compared to the same period in 2011. This increase is primarily due to an increase in the number of physicians we employ, annual merit and contractual wage increases for our employees, increased contract labor costs, increased annual incentive compensation expense, increased workers' compensation expense, increased health benefits costs and increased employee-related costs associated with our HIT implementation program,

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partially offset by decreased overtime expense. Included in salaries, wages and benefits expense in 2012 is $1 million of expense due to a 17 basis point decrease in the interest rate used to estimate the discounted present value of projected future workers' compensation liabilities, compared to a $4 million unfavorable adjustment as a result of a 136 basis point decrease in the interest rate in the year ended December 31, 2011. Salaries, wages and benefits expense for the years ended December 31, 2012 and 2011 also included stock-based compensation expense of $32 million and $24 million, respectively.

Salaries, wages and benefits expense for our Conifer segment increased by 22.9% in the year ended December 31, 2012 compared to the year ended December 31, 2011 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the new CHI partnership and Conifer's two acquisitions in 2012.

SUPPLIES

Supplies expense as a percentage of net operating revenues decreased 0.9% for the year ended December 31, 2012 compared to the year ended December 31, 2011. Supplies expense per adjusted patient admission decreased 1.9% in the year ended December 31, 2012 compared to the same period in 2011. Supplies expense was favorably impacted by lower pharmaceutical costs and a decline in orthopedic and cardiology-related costs due to renegotiated prices, partially offset by increased costs of implants and surgical supplies. In general, supplies expense changes are primarily attributable to changes in our patient volume levels and the mix of procedures performed.

OTHER OPERATING EXPENSES, NET

Other operating expenses as a percentage of net operating revenues was 23.5% in the year ended December 31, 2012 compared to 23.4% in the year ended December 31, 2011. Other operating expenses per adjusted patient admission increased by 2.6% in the year ended December 31, 2012 compared to the same period in 2011. The increase in other operating expenses for our Hospital Operations and other segment is primarily due to:

- increased costs of contracted services ($33 million), primarily due to additional physician practices we acquired;
- higher consulting and legal costs of $23 million, which includes costs related to the aforementioned Medicare Budget Neutrality settlement and various managed care payer settlements;
- increased systems implementation costs ($17 million), primarily related to our HIT implementation program;
- increased rent and lease expenses ($14 million);
- $13 million of costs associated with funding indigent care services by certain of our Texas hospitals beginning in the three months ended December 31, 2012; and
- gains totaling $4 million from the sale of land and buildings in the 2012 period compared to gains of $8 million from the sale of a building at the former campus of one of our hospitals and a medical office building in the 2011 period.

These increases were partially offset by decreased physician relocation expenses ($9 million).

Malpractice expense was $92 million in the year ended December 31, 2012, which included an unfavorable adjustment of approximately $2 million due to a 17 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities, compared to malpractice expense of $108 million in the year ended December 31, 2011, which included an unfavorable adjustment of approximately $17 million due to a 136 basis point decrease in the interest rate. The amount of malpractice expense in the year ended December 31, 2012 may not necessarily be indicative of malpractice expense amounts in future years due to changes in loss experience and interest rates used to estimate the discounted present value of projected future malpractice liabilities.

Other operating expenses for our Conifer segment increased by 44.6% in the year ended December 31, 2012 compared to the year ended December 31, 2011 primarily due to additional operating expenses related to the new CHI partnership and Conifer's two acquisitions in 2012.

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IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL, AND RESTRUCTURING CHARGES

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of $19 million, consisting of $3 million relating to the impairment of obsolete assets, $2 million relating to other impairment charges, $8 million of employee severance costs and $6 million of other related costs.

During the year ended December 31, 2011, we recorded net impairment and restructuring charges of $20 million. This amount included a $6 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors contributing to the adverse financial trends at that time included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $20 million as of December 31, 2011 after recording the impairment charge. In addition, we recorded impairment charges of $1 million in connection with the sale of seven medical office buildings in Texas, $1 million related to a cost basis investment, $7 million in employee severance costs, $3 million in lease termination costs, $1 million of acceleration of stock-based compensation costs and $1 million of other related costs.

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the year ended December 31, 2012 were $5 million compared to $55 million for the year ended December 31, 2011. The 2012 amount primarily related to costs associated with various legal proceedings and governmental reviews. The 2011 amount primarily related to costs associated with our evaluation of an unsolicited acquisition proposal received in November 2010 (which was subsequently withdrawn), changes in reserve estimates established in connection with certain governmental reviews, accruals for a physician privileges case and certain hospital-related tort claims, the settlement of a union arbitration claim and costs to defend various matters.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2012 was $412 million compared to $375 million for the year ended December 31, 2011. The increase primarily related to a $30 million favorable impact from an interest rate swap agreement we terminated in August 2011. During the year ended December 31, 2011, the interest rate swap agreement generated approximately $8 million of cash interest savings and a $22 million gain on the settlement of the agreement. See Note 6 to the accompanying Consolidated Financial Statements for additional information about this agreement.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2012, we recorded a loss from early extinguishment of debt of approximately $4 million, primarily related to the difference between the purchase prices and the par values of the $161 million aggregate principal amount outstanding of our 7 ⅜% senior notes due 2013 that we purchased during the period. During the year ended December 31, 2011, we recorded a loss from early extinguishment of debt of approximately $117 million, primarily related to the difference between the purchase prices and the par values of the $713 million aggregate principal amount of 9% senior secured notes due 2015 that we purchased during the period, as well as the write-off of unamortized note discounts and issuance costs.

INCOME TAX EXPENSE

During the year ended December 31, 2012, we recorded income tax expense of $125 million compared to $61 million during the year ended December 31, 2011. See Note 16 to the accompanying Consolidated Financial Statements for additional information about income taxes.

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DISCONTINUED OPERATIONS: IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL, AND RESTRUCTURING CHARGES

During the year ended December 31, 2012, we recorded an impairment charge in discontinued operations of $100 million related to the sale of Creighton University Medical Center, consisting of $98 million for the write-down of long-lived assets to their estimated fair values and a $2 million charge for the write-down of goodwill.

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Our obligations to make future cash payments under contracts, such as debt and lease agreements, and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, are summarized in the table below, all as of December 31, 2013:

		Years Ending December 31,					Later
	Total	2014	2015	2016	2017	2018	Years
				(In Millions)			
Long-term debt(1)	$ 15,449	$ 736	$ 1,114	$ 1,023	$ 618	$ 1,659	$ 10,299
Capital lease obligations(1)	408	88	65	25	49	5	176
Long-term non-cancelable operating leases	663	137	117	102	80	56	171
Standby letters of credit	189	189	—	—	—	—	—
Guarantees(2)	126	74	30	17	5	—	—
Asset retirement obligations	142	—	—	—	—	—	142
Academic affiliation agreements(3)	209	44	29	29	29	17	61
Tax liabilities	29	—	—	—	—	—	29
Defined benefit plan obligations	553	28	20	20	20	20	445
Construction and capital improvements	466	190	150	63	63	—	—
Information technology contract services	1,364	227	164	167	169	172	465
Purchase orders	421	421	—	—	—	—	—
Total(4)	**$ 20,019**	**$ 2,134**	**$ 1,689**	**$ 1,446**	**$ 1,033**	**$ 1,929**	**$ 11,788**

(1) Includes interest through maturity date/lease termination.
(2) Includes minimum revenue guarantees, primarily related to physicians under relocation agreements and physician groups that provide services at our hospitals, and operating lease guarantees.
(3) These agreements contain various rights and termination provisions.
(4) Professional liability and workers' compensation reserves have been excluded from the table. At December 31, 2013, the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were approximately $156 million and $543 million, respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were approximately $55 million and $179 million, respectively.

Standby letters of credit are required principally by our insurers and various states to collateralize our workers' compensation programs pursuant to statutory requirements and as security to collateralize the deductible and self-insured retentions under certain of our professional and general liability insurance programs. The amount of collateral required is primarily dependent upon the level of claims activity and our creditworthiness. The insurers require the collateral in case we are unable to meet our obligations to claimants within the deductible or self-insured retention layers. The standby letters of credit are issued under our revolving credit facility, as amended November 29, 2011.

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2013:

- On October 1, 2013, we entered into supplemental indentures relating to the sale of $2.8 billion aggregate principal amount of 8 1/8% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. Interest payments for the life of these notes will be approximately $2.7 billion. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard, which closed on October 1, 2013. As part of the acquisition, we assumed Vanguard's cash obligations, including a capital expenditure commitment at Detroit Medical Center and remaining construction costs for a new hospital campus in New Braunfels, Texas and significant expansion at two hospitals, for a total of approximately $600 million.

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- Following our acquisition of Vanguard, in accordance with the terms of our Credit Agreement, on October 15, 2013, we increased the maximum aggregate principal amount of our revolving credit facility from $800 million to $1 billion, subject to borrowing availability.

- We entered into non-cancellable capital leases of approximately $341 million, primarily for equipment and three hospitals we previously leased under operating lease agreements.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our cash and our operating results. At December 31, 2013, using the last 12 months of Adjusted EBITDA, including Vanguard's last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 6.0x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including acquisitions that involve the assumption of long-term debt. We intend to manage this ratio by following our business plan, managing our cost structure and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections in Part I of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements. Capital expenditures were $691 million, $508 million and $475 million in the years ended December 31, 2013, 2012 and 2011, respectively, which included $2 million and $8 million in the years ended December 31, 2012 and 2011, respectively, related to discontinued operations. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2014 will total approximately $900 million to $1 billion, including $193 million that was accrued as a liability at December 31, 2013. Our budgeted 2014 capital expenditures include approximately $18 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree. We expect to spend approximately $13 million more on such improvements over the next two years.

During the year ended December 31, 2013, we acquired Vanguard for approximately $4.3 billion, or $21.00 per share of Vanguard stock, including the assumption of $2.5 billion of net Vanguard debt. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. The fair value of the consideration conveyed in the acquisitions was $1.515 billion.

Interest payments, net of capitalized interest, were $426 million, $376 million and $347 million in the years ended December 31, 2013, 2012 and 2011, respectively.

From time to time, we use interest rate swap agreements to manage our exposure to future changes in interest rates. We were party to an interest rate swap agreement for an aggregate notional amount of $600 million from February 14, 2011 through August 2, 2011. The interest rate swap agreement was designated as a fair value hedge. It had the effect of converting our 10% senior secured notes due 2018 from a fixed interest rate paid semi-annually to a variable interest rate paid semi-annually based on the six-month London Interbank Offered Rate plus a floating rate spread of 6.60%. During the term of the interest rate swap agreement, changes in the fair value of the interest rate swap agreement and changes in the fair value of the 10% senior secured notes were recorded in interest expense. During the year ended December 31, 2011, our interest rate swap agreement generated $8 million of cash interest savings and a $22 million gain on the settlement of the agreement.

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Income tax payments, net of tax refunds, were approximately $6 million in the year ended December 31, 2013 compared to approximately $13 million in the year ended December 31, 2012. At December 31, 2013, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.6 billion pretax expiring in 2024 to 2033, (2) approximately $19 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $14 million expiring in 2023 to 2031, and (4) state NOL carryforwards of $3.8 billion expiring in 2014 to 2033 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $34 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if our "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership by more than 50 percentage points (by value) over a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs, our offering of stock, the purchase or sale of our stock by five-percent shareholders, or the issuance or exercise of rights to acquire our stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount of taxable income we generate in future periods.

Periodic examinations of our tax returns by the Internal Revenue Service ("IRS") or other taxing authorities could result in the payment of additional taxes. The IRS has completed audits of our tax returns for all tax years ended on or before December 31, 2007. All disputed issues with respect to these audits have been resolved, and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007 and Vanguard's tax returns for fiscal years after June 30, 2004 are subject to examination by the IRS.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2013 was primarily derived from net cash provided by operating activities, cash on hand and borrowings under our revolving credit facility. We had approximately $113 million of cash and cash equivalents on hand at December 31, 2013 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $406 million based on our borrowing base calculation as of December 31, 2013.

Our primary source of operating cash is the collection of accounts receivable. As such, our operating cash flow is negatively impacted by lower levels of cash collections and higher levels of bad debt due to unfavorable shifts in payer mix, growth in admissions of uninsured and underinsured patients, and other factors.

Net cash provided by operating activities was $589 million in the year ended December 31, 2013 compared to $593 million in the year ended December 31, 2012. Key negative and positive factors contributing to the change between the 2013 and 2012 periods include the following:

- Increased income from continuing operations before income taxes of $139 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, litigation and investigation costs, impairment and restructuring charges, acquisition-related costs, and depreciation and amortization in the year ended December 31, 2013 compared to the year ended December 31, 2012;
- The unfavorable impact of increased DSH receivables of $30 million primarily related to the Texas uncompensated care 1115 waiver program;
- $20 million less cash used in operating activities from discontinued operations;
- An increase of $51 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;
- $50 million of additional interest payments primarily due to $37 million of interest payments related to the Vanguard debt refinanced in connection with the acquisition on October 1, 2013; and
- Income tax payments of $6 million in the year ended December 31, 2013 compared to $13 million in the year ended December 31, 2012.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash. These initiatives may include the sale of excess land, buildings or other underutilized or inefficient assets.

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Capital expenditures were $691 million and $508 million in the years ended December 31, 2013 and 2012, respectively.

In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase program, we paid approximately $100 million to repurchase a total of 3,406,324 shares during the period from the commencement of the program through December 31, 2012, and we paid approximately $400 million to repurchase a total of 9,484,974 shares during the period from January 1, 2013 to December 31, 2013.

We record our investments that are available-for-sale at fair market value. As shown in Note 13 to the Condensed Consolidated Financial Statements, the majority of our investments are valued based on quoted market prices or other observable inputs. We have no investments that we expect will be negatively affected by the current economic downturn that will materially impact our financial condition, results of operations or cash flows.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

We have a senior secured revolving credit facility (as amended, the "Credit Agreement"), that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016, subject to our repayment or refinancing on or before November 3, 2014 of approximately $238 million of the aggregate outstanding principal amount of our 9 1/4% senior notes due 2015 (approximately $474 million of which was outstanding at December 31, 2013). If such repayment or refinancing does not occur, borrowings under the Credit Agreement will be due November 3, 2014. We are in compliance with all covenants and conditions in our Credit Agreement. There were $405 million of cash borrowings outstanding under the revolving credit facility at December 30, 2013, and we had approximately $189 million of standby letters of credit outstanding. Our borrowing availability under the Credit Agreement was $406 million based on our borrowing base calculation as of December 31, 2013.

In October 2013, we sold $2.8 billion aggregate principal amount of 8 1/8% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8 1/8% senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard. In addition, in accordance with the terms of the Credit Agreement, on October 15, 2013, we increased the maximum aggregate principal amount of our revolving credit facility from $800 million to $1 billion, subject to borrowing availability.

In May 2013, we sold $1.050 billion aggregate principal amount of 4 3/8% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4 3/8% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, commencing on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately $767 million aggregate principal amount outstanding of our 8 7/8% senior secured notes due 2019 in a tender offer and to call approximately $158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold $850 million aggregate principal amount of 4 1/2% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4 1/2% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately $645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately $69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $177 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

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For additional information regarding our long-term debt, see Note 6 to the accompanying Consolidated Financial Statements.

LIQUIDITY

From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time. We believe our existing debt agreements, the significant recent changes to which are described above, provide significant flexibility for future secured or unsecured borrowings.

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest and income tax payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that has caused, and in the future could cause, us to use our senior secured revolving credit facility as a source of liquidity. We believe that existing cash and cash equivalents on hand, availability under our revolving credit facility, anticipated future cash provided by operating activities, and our investments in marketable securities of our captive insurance companies classified as noncurrent investments on our balance sheet should be adequate to meet our current cash needs. These sources of liquidity should also be adequate to finance planned capital expenditures, payments on the current portion of our long-term debt and other presently known operating needs.

Long-term liquidity for debt service will be dependent on improved cash provided by operating activities and, given favorable market conditions, future borrowings or refinancings. However, our cash requirements could be materially affected by the use of cash in acquisitions of businesses and repurchases of securities, and also by a deterioration in our results of operations, as well as the various uncertainties discussed in this and other sections of this report, which could require us to pursue any number of financing options, including, but not limited to, additional borrowings, debt refinancings, asset sales or other financing alternatives. The level, if any, of these financing sources cannot be assured.

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our period-end balance sheets. We do not have any significant European sovereign debt exposure.

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are volume growth, including the acquisition of outpatient businesses, physician recruitment and alignment strategies, expansion of our services businesses within Conifer, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, underperforming hospitals, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management peers because of geographic and other differences in hospital portfolios.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the years ended December 31, 2013, 2012 and 2011 include $392 million, $953 million and $908 million, respectively, of net operating revenues and $72 million, $132 million and $115 million, respectively, of operating income generated from general hospitals operated by us under operating lease arrangements (one hospital as of December 31, 2013 and four hospitals of December 31, 2012 and 2011). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet. The one remaining operating lease is currently scheduled to expire in 2027. If we are unable to extend this lease or purchase the hospital, we would no longer generate revenues or expenses from the hospital.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $315 million of standby letters of credit outstanding and guarantees as of December 31, 2013.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 21 to our Consolidated Financial Statements included in this report for a discussion of recently issued accounting standards.

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CRITICAL ACCOUNTING ESTIMATES

In preparing our Consolidated Financial Statements in conformity with GAAP, we must use estimates and assumptions that affect the amounts reported in our Consolidated Financial Statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable, given the particular circumstances in which we operate. Actual results may vary from those estimates.

We consider our critical accounting estimates to be those that (1) involve significant judgments and uncertainties, (2) require estimates that are more difficult for management to determine, and (3) may produce materially different outcomes under different conditions or when using different assumptions.

Our critical accounting estimates cover the following areas:

- Recognition of net operating revenues, including contractual allowances and provision for doubtful accounts;
- Electronic health record incentives;
- Accruals for general and professional liability risks;
- Accruals for defined benefit plans;
- Impairment of long-lived assets;
- Impairment of goodwill, and
- Accounting for income taxes.

REVENUE RECOGNITION

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, and managed care and other health plans, as well as certain uninsured patients under the Compact.

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as DSH, DGME, IME and bad debt expense, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded by us could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of December 31, 2013, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $13 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in

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reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

Revenues related to self-pay patients may qualify for a discount under the Compact, whereby the gross charges based on established billing rates would be reduced by an estimated discount for contractual allowance.

We believe that adequate provision has been made for any adjustments that may result from final determination of amounts earned under all the above arrangements. We know of no material claims, disputes or unsettled matters with any payers that would affect our revenues for which we have not adequately provided for in our Consolidated Financial Statements.

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance as of December 31, 2012, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonable likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Our practice is to reduce the net carrying value of self-pay accounts receivable, including accounts related to the co-pays and deductibles due from patients with insurance, to their estimated net realizable value at the time of billing. Generally, uncollected balances are assigned to Conifer between 90 to 180 days, once patient responsibility has been identified. When accounts are assigned to Conifer by the hospital, the accounts are completely written off the hospital's books through the provision for doubtful accounts, and an estimated future recovery amount is calculated and recorded as a receivable on the hospital's books at the same time. The estimated future recovery amount is adjusted based on the aging of the accounts and changes to actual recovery rates. The estimated future recovery amount for self-pay accounts is written down whereby it is fully reserved if the amount is not paid within two years after the account is assigned to Conifer. At the present time, our new acquisitions have not been fully integrated into our Conifer collections processes.

Managed care accounts are collected through the regional business offices of Conifer, whereby the account balances remain in the related hospital's patient accounting system and on the hospital's books, and are adjusted based on an analysis of the net realizable value as they age. Generally, managed care accounts collected by Conifer are gradually written down whereby they are fully reserved if the accounts are not paid within two years.

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Changes in the collectability of aged managed care accounts receivable are ongoing and impact our provision for doubtful accounts. We continue to experience payment pressure from managed care companies concerning amounts of past billings. We aggressively pursue collection of these accounts receivable using all means at our disposal, including arbitration and litigation, but we may not be successful.

ELECTRONIC HEALTH RECORD INCENTIVES

Under certain provisions of ARRA, federal incentive payments are available to hospitals, physicians and certain other professionals when they adopt, implement or upgrade ("AIU") certified EHR technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. Hospitals that are meaningful users under the Medicare EHR incentive payment program are deemed meaningful users under the Medicaid EHR incentive payment program and do not need to meet additional criteria imposed by a state. Medicaid EHR incentive payments to providers are 100% federally funded and administered by the states. CMS established calendar year 2011 as the first year states could offer EHR incentive payments. Before a state may offer EHR incentive payments, the state must submit and CMS must approve the state's incentive plan.

We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved.

The meaningful use information submitted to CMS is subject to review, verification and audit. Additionally, the final Medicare and Medicaid EHR incentive payments under ARRA are based on financial and statistical data, which may be estimated using historical trends and current factors, in the settled Medicare cost report for the cost reporting period that begins in the federal fiscal year in which the criteria are met. We have acquired, developed and implemented systems to accumulate the information necessary to demonstrate meaningful use of EHR technology. We also have a system and estimation process for recording the financial and statistical data utilized as part of the cost reporting process. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. Cost report settlements are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded by us could change by material amounts. Final settlement of cost reports, which could impact the financial and statistical data on which EHR incentives are based, or a determination that meaningful use was not attained could result in adjustment to previously recognized EHR incentive payments or retrospective recoupment of incentive payments.

ACCRUALS FOR GENERAL AND PROFESSIONAL LIABILITY RISKS

We accrue for estimated professional and general liability claims, to the extent not covered by insurance, when they are probable and can be reasonably estimated. We maintain reserves, which are based on actuarial estimates for the portion of our professional liability risks, including incurred but not reported claims, to the extent we do not have insurance coverage. Our liability consists of estimates established based upon discounted actuarial calculations using several factors, including the number of expected claims, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, the timing of historical payments, and risk free discount rates used to determine the present value of projected payments. We consider the number of expected claims, average cost per claim and discount rate to be the most significant assumptions in estimating accruals for general and professional liabilities. Our liabilities are adjusted for new claims information in the period such information becomes known. Malpractice expense is recorded within other operating expenses in the accompanying Consolidated Statements of Operations.

Our estimated reserves for professional and general liability claims will change significantly if future claims differ from expected trends. We believe it is reasonably likely for there to be a 5% increase or decrease in the number of expected claims or average cost per claim. Based on our reserves and other information as of December 31, 2013, a 5% increase in the number of

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expected claims would increase the estimated reserves by $37 million, and a 5% decrease in the number of expected claims would decrease the estimated reserves by $33 million. A 5% increase in the average cost per claim would increase the estimated reserves by $52 million, and a 5% decrease in the average cost per claim would decrease the estimated reserves by $46 million. Because our estimated reserves for future claim payments are discounted to present value, a change in our discount rate assumption could also have a significant impact on our estimated reserves. Our discount rate was 2.45%, 1.18% and 1.35% at December 31, 2013, 2012 and 2011, respectively. A 100 basis point increase or decrease in the discount rate would change the estimated reserves by $17 million. In addition, because of the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes, our ultimate liability for professional and general liability claims could change materially from our current estimates.

The table below shows the case reserves and incurred but not reported and loss development reserves as of December 31, 2013, 2012 and 2011:

	December 31,		
	2013	2012	2011
Case reserves	$ 175	$ 97	$ 111
Incurred but not reported and loss development reserves	575	272	319
Total undiscounted reserves	**$ 750**	**$ 369**	**$ 430**

Several actuarial methods, including the incurred, paid loss development and Bornhuetter-Ferguson methods, are applied to our historical loss data to produce estimates of ultimate expected losses and the resulting incurred but not reported and loss development reserves. These methods use our specific historical claims data related to paid losses and loss adjustment expenses, historical and current case reserves, reported and closed claim counts, and a variety of hospital census information. Based on these analyses, we determine our estimate of the professional liability claims, including the incurred but not reported and loss development reserve estimates. The determination of our estimates involves subjective judgment and could result in material changes to our estimates in future periods if our actual experience is materially different than our assumptions.

Malpractice claims generally take 4 to 5 years to settle from the time of the initial reporting of the occurrence to the settlement payment. Accordingly, the percentage of undiscounted reserves as of both December 31, 2013 and 2012 representing unsettled claims is approximately 99%.

The following table, which includes both our continuing and discontinued operations, presents the amount of our accruals for professional and general liability claims and the corresponding activity therein:

	Years Ended December 31,		
	2013	2012	2011
Accrual for professional and general liability claims, beginning of the year	$ 356	$ 412	$ 467
Assumed from acquisition	361	0	0
Expense (income) related to:(1)			
Current year	102	86	107
Prior years	13	(2)	10
Expense (income) from discounting	(13)	4	22
Total incurred loss and loss expense	102	88	139
Paid claims and expenses related to:			
Current year	(3)	(2)	(2)
Prior years	(117)	(142)	(192)
Total paid claims and expenses	(120)	(144)	(194)
Accrual for professional and general liability claims, end of year	**$ 699**	**$ 356**	**$ 412**

(1) Total malpractice expense for continuing operations, including premiums for insured coverage, was $112 million, $92 million and $108 million in the years ended December 31, 2013, 2012 and 2011, respectively.

ACCRUALS FOR DEFINED BENEFIT PLANS

Our defined benefit plan obligations and related costs are calculated using actuarial concepts. The discount rate is a critical assumption in determining the elements of expense and liability measurement. We evaluate this critical assumption

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annually. Other assumptions include employee demographic factors such as retirement patterns, mortality, turnover and rate of compensation increase.

The discount rate enables us to state expected future cash payments for benefits as a present value on the measurement date. The guideline for setting these rates is a high-quality long-term corporate bond rate. A lower discount rate increases the present value of benefit obligations and increases pension expense. Our discount rates for 2013 ranged from 5.00% to 5.18% and our discount rate for 2012 was 4.00%. The assumed discount rate for pension plans reflects the market rates for high-quality corporate bonds currently available. A 100 basis point decrease in the assumed discount rate would increase total net periodic pension expense for 2013 by approximately $7 million and would increase the projected benefit obligation at December 31, 2013 by approximately $157 million. A 100 basis point increase in the assumed discount rate would decrease net periodic pension expense for 2014 by approximately $5 million and decrease the projected benefit obligation at December 31, 2013 by approximately $131 million.

IMPAIRMENT OF LONG-LIVED ASSETS

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment charge if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the following risks:

- future financial results of our hospitals, which can be impacted by volumes of insured patients and declines in commercial managed care patients, terms of managed care payer arrangements, our ability to collect accounts due from uninsured and managed care payers, loss of volumes as a result of competition, and our ability to manage costs such as labor costs, which can be adversely impacted by union activity and the shortage of experienced nurses;

- changes in payments from governmental health care programs and in government regulations such as reductions to Medicare and Medicaid payment rates resulting from government legislation or rule-making or from budgetary challenges of states in which we operate;

- how the hospitals are operated in the future; and

- the nature of the ultimate disposition of the assets.

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the

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hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment continues to decline. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination costs, and $59 million in acquisition-related costs. Additionally, in our most recent impairment analysis as of December 31, 2013, we had two hospitals with an aggregate carrying value of long-lived assets of approximately $227 million whose estimated future undiscounted cash flows exceeded the carrying value of long-lived assets by an aggregate amount of approximately $150 million. These two hospitals had the smallest excess of future undiscounted cash flows on an annual basis necessary to recover the carrying value of their assets. We also had one hospital whose estimated future undiscounted cash flows did not exceed the carrying value of long-lived assets. However, the fair value of those assets, based on an independent appraisal, exceeded the carrying value by $23 million, so no impairment was recorded. Future adverse trends that result in necessary changes in the assumptions underlying these estimates of future undiscounted cash flows could result in the hospitals' estimated cash flows being less than the carrying value of the assets, which would require a fair value assessment of the long-lived assets and, if the fair value amount is less than the carrying value of the assets, impairment charges would occur and could be material.

IMPAIRMENT OF GOODWILL

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level, as defined by applicable accounting standards, when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

As of December 31, 2013, our continuing operations consisted of two operating segments, our Conifer subsidiary and our hospital and other operations. In the three months ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard, and we moved our hospitals in Philadelphia, Pennsylvania from our Southern States region into our Northeast region. Our hospital and other operations segment was structured as follows as of December 31, 2013:

- Our California region included all of our hospitals and other operations in California;
- Our Central region included all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the San Antonio or South Texas markets;
- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern States region included all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;
- Our Detroit market region included all of our hospitals and other operations in the Detroit, Michigan area;
- Our Phoenix market included all of our hospitals and other operations in the Phoenix, Arizona area;
- Our San Antonio market included all of our hospitals and other operations in the San Antonio, Texas area; and

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- Our South Texas market included all of our hospitals and other operations in the Brownsville, Texas and Harlingen, Texas areas.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

The goodwill balance related to our acquisition of Vanguard has not yet been allocated by reporting unit. Our allocated goodwill balance is primarily related to our Southern States region, which totals approximately $388 million, and our Central region, which totals approximately $370 million. In our latest impairment analysis as of December 31, 2013, the estimated fair value of these regions exceeded the carrying value of long-lived assets, including goodwill, by approximately 18% and 116%, respectively.

ACCOUNTING FOR INCOME TAXES

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions items requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;
- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

During the year ended December 31, 2011, we reduced our valuation allowance by $5 million based on 2011 profits and projected profits for 2012. During the year ended December 31, 2012, we reduced the valuation allowance by an additional $5 million based on 2012 profits and projected profits for 2013. During the year ended December 31, 2013, the valuation allowance increased by $51 million, $28 million due to the acquisition of Vanguard and $23 million primarily due to the recording of deferred tax assets for state net operating loss carryforwards that have a full valuation allowance. The remaining $107 million balance in the valuation allowance as of December 31, 2013 is primarily attributable to certain state net operating loss carryovers that, more likely than not, will expire unutilized.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

While we believe we have adequately provided for our income tax receivables or liabilities and our deferred tax assets or liabilities, adverse determinations by taxing authorities or changes in tax laws and regulations could have a material adverse effect on our consolidated financial position, results of operations or cash flows.

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ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments as of December 31, 2013. The fair values were determined based on quoted market prices for the same or similar instruments. The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2014	2015	2016	2017	2018	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 149	$ 539	$ 25	$ 49	$ 1,047	$ 8,653	$ 10,462	$ 10,833
Average effective interest rates	7.0%	8.9%	5.3%	8.7%	6.6%	7.0%	7.0%	
Variable rate long-term debt	$ —	$ —	$ 405	$ —	$ —	$ —	$ 405	$ 405
Average effective interest rates	—	—	2.38%	—	—	—	2.38%	

At December 31, 2013, the potential reduction of annual pretax earnings due to a one percentage point (100 basis point) increase in variable interest rates on long-term debt would be approximately $4 million.

At December 31, 2013, we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as "special-purpose" or "variable-interest" entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements by us. Thus, we have no exposure to the financing, liquidity, market or credit risks associated with such entities.

We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage or prepayment features.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

To Our Shareholders:

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended. Management assessed the effectiveness of Tenet's internal control over financial reporting as of December 31, 2013. This assessment was performed under the supervision of and with the participation of management, including the chief executive officer and chief financial officer.

In making this assessment, management used criteria based on the framework in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on the assessment using the COSO framework, management concluded that Tenet's internal control over financial reporting was effective as of December 31, 2013.

As more fully described under the heading "Basis of Presentation" in Note 1 to the Consolidated Financial Statements in Item 8, we acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013. We excluded Vanguard from our 2013 assessment of the effectiveness of our internal control over financial reporting. Vanguard accounted for approximately 12% and 39% of net and total assets, respectively, and 13% of net operating revenues of our consolidated financial statement amounts as of and for the year ended December 31, 2013. We expect that our internal control system will be fully implemented at Vanguard during 2014 and correspondingly evaluated by us for effectiveness.

Tenet's internal control over financial reporting as of December 31, 2013 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report, which is included herein. Deloitte & Touche LLP has also audited Tenet's Consolidated Financial Statements as of and for the year ended December 31, 2013, and that firm's audit report on such Consolidated Financial Statements is also included herein.

Internal control over financial reporting cannot provide absolute assurance of achieving financial reporting objectives because of its inherent limitations. Internal control over financial reporting is a process that involves human diligence and compliance and is subject to lapses in judgment and breakdowns resulting from human failures. Internal control over financial reporting also can be circumvented by collusion or improper management override. Because of such limitations, there is a risk that material misstatements may not be prevented or detected on a timely basis by internal control over financial reporting. However, these inherent limitations are known features of the financial reporting process. Therefore, it is possible to design into the process safeguards to reduce, though not eliminate, this risk.

/s/ TREVOR FETTER	/s/ DANIEL J. CANCELMI
Trevor Fetter	Daniel J. Cancelmi
President and Chief Executive Officer	*Chief Financial Officer*
February 24, 2014	February 24, 2014

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2013, based on criteria established in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in Management's Report on Internal Control Over Financial Reporting, management excluded from its assessment the internal control over financial reporting at Vanguard Health Systems, Inc., which was acquired on October 1, 2013 and whose financial statements constitute 12% and 39% of net and total assets, respectively, and 13% of net operating revenues of the consolidated financial statement amounts as of and for the year ended December 31, 2013. Accordingly, our audit did not include the internal control over financial reporting at Vanguard Health Systems, Inc. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on the criteria established in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 20 13 of the Company and our report dated February 24, 2014 expressed an unqualified opinion on those financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 24, 2014

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2013 and 2012, and the related consolidated statements of operations, other comprehensive income (loss), changes in equity, and cash flows for each of the three years in the period ended December 31, 2013. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Tenet Healthcare Corporation and subsidiaries at December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2013, based on the criteria established in *Internal Control* — Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 24, 2014 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 24, 2014

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CONSOLIDATED BALANCE SHEETS
Dollars in Millions

	December 31, 2013	December 31, 2012
ASSETS		
Current assets:		
Cash and cash equivalents	$ 113	$ 364
Accounts receivable, less allowance for doubtful accounts ($589 at December 31, 2013 and $401 at December 31, 2012)	2,038	1,345
Inventories of supplies, at cost	262	153
Income tax receivable	0	7
Current portion of deferred income taxes	581	354
Other current assets	716	458
Total current assets	**3,710**	**2,681**
Investments and other assets	405	162
Deferred income taxes, net of current portion	90	342
Property and equipment, at cost, less accumulated depreciation and amortization ($3,898 at December 31, 2013 and $3,494 at December 31, 2012)	7,691	4,293
Goodwill	3,042	916
Other intangible assets, at cost, less accumulated amortization ($523 at December 31, 2013 and $426 at December 31, 2012)	1,192	650
Total assets	**$ 16,130**	**$ 9,044**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 149	$ 94
Accounts payable	1,075	722
Accrued compensation and benefits	631	415
Professional and general liability reserves	156	64
Accrued interest payable	198	125
Other current liabilities	719	343
Total current liabilities	**2,928**	**1,763**
Long-term debt, net of current portion	10,690	5,158
Professional and general liability reserves	543	292
Defined benefit plan obligations	398	292
Other long-term liabilities	446	305
Total liabilities	**15,005**	**7,810**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	247	16
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 144,057,351 shares issued at December 31, 2013 and 142,363,915 shares issued at December 31, 2012	7	7
Additional paid-in capital	4,572	4,471
Accumulated other comprehensive loss	(24)	(68)
Accumulated deficit	(1,422)	(1,288)
Common stock in treasury, at cost, 47,197,722 shares at December 31, 2013 and 37,730,431 shares at December 31, 2012	(2,378)	(1,979)
Total shareholders' equity	**755**	**1,143**
Noncontrolling interests	**123**	**75**
Total equity	**878**	**1,218**
Total liabilities and equity	**$ 16,130**	**$ 9,044**

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts

	Years Ended December 31,		
	2013	2012	2011
Net operating revenues:			
Net operating revenues before provision for doubtful accounts	$ 12,074	$ 9,904	$ 9,371
Less: Provision for doubtful accounts	972	785	717
Net operating revenues	**11,102**	**9,119**	**8,654**
Operating expenses:			
Salaries, wages and benefits	5,371	4,257	4,015
Supplies	1,784	1,552	1,548
Other operating expenses, net	2,701	2,147	2,020
Electronic health record incentives	(96)	(40)	(55)
Depreciation and amortization	545	430	398
Impairment and restructuring charges, and acquisition-related costs	103	19	20
Litigation and investigation costs	31	5	55
Operating income	**663**	**749**	**653**
Interest expense	(474)	(412)	(375)
Loss from early extinguishment of debt	(348)	(4)	(117)
Investment earnings	1	1	3
Income (loss) from continuing operations, before income taxes	**(158)**	**334**	**164**
Income tax benefit (expense)	65	(125)	(61)
Income (loss) from continuing operations, before discontinued operations	**(93)**	**209**	**103**
Discontinued operations:			
Loss from operations	(5)	(2)	(18)
Impairment of long-lived assets and goodwill, and restructuring charges, net	(0)	(100)	(6)
Litigation and investigation costs	(2)	0	(17)
Net gains on sales of facilities	0	1	0
Income tax benefit (expense)	(4)	25	32
Loss from discontinued operations	**(11)**	**(76)**	**(9)**
Net income (loss)	**(104)**	**133**	**94**
Less: Preferred stock dividends	0	11	24
Less: Net income (loss) attributable to noncontrolling interests			
Continuing operations	30	13	11
Discontinued operations	(0)	(32)	1
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ (134)**	**$ 141**	**$ 58**
Amounts attributable to Tenet Healthcare Corporation common shareholders			
Income (loss) from continuing operations, net of tax	$ (123)	$ 185	$ 68
Loss from discontinued operations, net of tax	(11)	(44)	(10)
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ (134)**	**$ 141**	**$ 58**
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:			
Basic			
Continuing operations	$ (1.21)	$ 1.77	$ 0.58
Discontinued operations	(0.11)	(0.42)	(0.09)
	$ (1.32)	**$ 1.35**	**$ 0.49**
Diluted			
Continuing operations	$ (1.21)	$ 1.70	$ 0.56
Discontinued operations	(0.11)	(0.40)	(0.08)
	$ (1.32)	**$ 1.30**	**$ 0.48**
Weighted average shares and dilutive securities outstanding (in thousands):			
Basic	101,648	104,200	117,182
Diluted	101,648	108,926	121,295

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME (LOSS)
Dollars in Millions

	Years Ended December 31,		
	2013	2012	2011
Net income (loss)	$ (104)	$ 133	$ 94
Other comprehensive income (loss):			
Adjustments for defined benefit plans	68	(25)	(15)
Unrealized gains on securities held as available-for-sale	1	0	0
Reclassification adjustments for realized losses included in net income	0	0	0
Other comprehensive income (loss) before income taxes	**69**	**(25)**	**(15)**
Income tax benefit (expense) related to items of other comprehensive loss	(25)	9	6
Total other comprehensive income (loss), net of tax	**44**	**(16)**	**(9)**
Comprehensive income (loss)	**(60)**	**117**	**85**
Less: Preferred stock dividends	**0**	**11**	**24**
Less: Comprehensive income (loss) attributable to noncontrolling interests	**30**	**(19)**	**12**
Comprehensive income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ (90)**	**$ 125**	**$ 49**

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
Dollars in Millions, Share Amounts in Thousands

	Tenet Healthcare Corporation Shareholders' Equity									
	Preferred Stock		Common Stock							
	Shares Outstanding	Issued Amount	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balances at December 31, 2010	345	$ 334	121,446	$ 7	$ 4,469	$ (43)	$ (1,522)	$ (1,479)	$ 53	$ 1,819
Net income	0	0	0	0	0	0	82	0	12	94
Distributions paid to noncontrolling interests	0	0	0	0	0	0	0	0	(10)	(10)
Other comprehensive loss	0	0	0	0	0	(9)	0	0	0	(9)
Purchases of businesses or joint venture interests	0	0	0	0	0	0	0	0	14	14
Preferred stock dividends	0	0	0	0	(24)	0	0	0	0	(24)
Repurchases of common stock	0	0	(18,942)	0	0	0	0	(374)	0	(374)
Stock-based compensation expense and issuance of common stock	0	0	1,252	0	(18)	0	0	0	0	(18)
Balances at December 31, 2011	345	$ 334	103,756	$ 7	$ 4,427	$ (52)	$ (1,440)	$ (1,853)	$ 69	$ 1,492
Net income (loss)	0	0	0	0	0	0	152	0	(22)	130
Distributions paid to noncontrolling interests	0	0	0	0	0	0	0	0	(12)	(12)
Contributions from noncontrolling interests	0	0	0	0	0	0	0	0	3	3
Other comprehensive loss	0	0	0	0	0	(16)	0	0	0	(16)
Purchases of businesses or joint venture interests	0	0	0	0	0	0	0	0	37	37
Preferred stock dividends	0	0	0	0	(11)	0	0	0	0	(11)
Repurchases of common stock	0	0	(4,733)	0	0	0	0	(126)	0	(126)
Repurchases of preferred stock	(299)	(289)	0	0	0	0	0	0	0	(289)
Conversion of preferred stock to common stock	(46)	(45)	1,979	0	45	0	0	0	0	0
Stock-based compensation expense and issuance of common stock	0	0	3,631	0	10	0	0	0	0	10
Balances at December 31, 2012	0	$ 0	104,633	$ 7	$ 4,471	$ (68)	$ (1,288)	$ (1,979)	$ 75	$ 1,218
Net income (loss)	0	0	0	0	0	0	(134)	0	21	(113)
Distributions paid to noncontrolling interests	0	0	0	0	0	0	0	0	(22)	(22)
Other comprehensive income	0	0	0	0	0	44	0	0	0	44
Contributions from noncontrolling interests	0	0	0	0	56	0	0	0	49	105
Repurchases of common stock	0	0	(9,485)	0	0	0	0	(400)	0	(400)
Stock-based compensation expense and issuance of common stock	0	0	1,712	0	45	0	0	1	0	46
Balances at December 31, 2013	0	$ 0	96,860	$ 7	$ 4,572	$ (24)	$ (1,422)	$ (2,378)	$ 123	$ 878

See accompanying Notes to Consolidated Financial Statements.

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CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions

	Years Ended December 31,		
	2013	2012	2011
Net income (loss)	**$ (104)**	**$ 133**	**$ 94**
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	545	430	398
Provision for doubtful accounts	972	785	717
Deferred income tax expense (benefit)	(67)	92	81
Stock-based compensation expense	36	32	24
Impairment and restructuring charges, and acquisition-related costs	103	19	20
Litigation and investigation costs	31	5	55
Loss from early extinguishment of debt	348	4	117
Amortization of debt discount and debt issuance costs	19	22	30
Pre-tax loss (gain) from discontinued operations	7	101	41
Other items, net	(33)	(12)	(13)
Changes in cash from operating assets and liabilities:			
Accounts receivable	(1,060)	(868)	(850)
Inventories and other current assets	(130)	(59)	(35)
Income taxes	0	(5)	(63)
Accounts payable, accrued expenses and other current liabilities	38	9	(32)
Other long-term liabilities	13	3	(5)
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(114)**	**(63)**	**(44)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(15)**	**(35)**	**(38)**
Net cash provided by operating activities	**589**	**593**	**497**
Cash flows from investing activities:			
Purchases of property and equipment — continuing operations	(691)	(506)	(467)
Purchases of property and equipment — discontinued operations	0	(2)	(8)
Purchases of businesses or joint venture interests, net of cash acquired	(1,515)	(211)	(84)
Proceeds from sales of facilities and other assets — discontinued operations	16	45	0
Proceeds from sales of marketable securities, long-term investments and other assets	15	17	59
Other long-term assets	8	(9)	(2)
Other items, net	3	4	(1)
Net cash used in investing activities	**(2,164)**	**(662)**	**(503)**
Cash flows from financing activities:			
Repayments of borrowings under credit facility	(1,286)	(1,773)	(365)
Proceeds from borrowings under credit facility	1,691	1,693	445
Repayments of other borrowings	(5,133)	(248)	(843)
Proceeds from other borrowings	6,507	1,092	900
Repurchases of preferred stock	0	(292)	0
Deferred debt issuance costs	(154)	(17)	(21)
Repurchases of common stock	(400)	(126)	(374)
Cash dividends on preferred stock	0	(14)	(24)
Distributions paid to noncontrolling interests	(27)	(15)	(10)
Contributions from noncontrolling interests	99	3	0
Proceeds from exercise of stock options	22	11	3
Other items, net	5	6	3
Net cash provided by (used in) financing activities	**1,324**	**320**	**(286)**
Net increase (decrease) in cash and cash equivalents	(251)	251	(292)
Cash and cash equivalents at beginning of period	364	113	405
Cash and cash equivalents at end of period	**$ 113**	**$ 364**	**$ 113**
Supplemental disclosures:			
Interest paid, net of capitalized interest	$ (426)	$ (376)	$ (347)
Proceeds from interest rate swap agreement	$ 0	$ 0	$ 30
Income tax payments, net	$ (6)	$ (13)	$ (10)

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. SIGNIFICANT ACCOUNTING POLICIES

Description of Business

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is an investor-owned health care services company whose subsidiaries and affiliates as of December 31, 2013 primarily operated 77 hospitals with a total of 20,293 licensed beds, 183 outpatient centers, six health plans, six accountable care networks and Conifer Health Solutions, LLC ("Conifer"), which provides business process solutions to more than 700 hospital and other clients nationwide.

Basis of Presentation

Our Consolidated Financial Statements include the accounts of Tenet and its wholly owned and majority-owned subsidiaries. We eliminate intercompany accounts and transactions in consolidation, and we include the results of operations of businesses that are newly acquired in purchase transactions from their dates of acquisition. We account for significant investments in other affiliated companies using the equity method. Unless otherwise indicated, all financial and statistical data included in these notes to our Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). Certain balances in the accompanying Consolidated Financial Statements and these notes have been reclassified to give retrospective presentation for the discontinued operations described in Note 4. Furthermore, all amounts related to shares, share prices and earnings per share have been restated to give retrospective presentation for the reverse stock split described in Note 2.

Effective October 1, 2013, we acquired the common stock of Vanguard Health Systems, Inc. ("Vanguard") for $21 per share in an all cash transaction. Vanguard owned and operated 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas. We paid approximately $4.3 billion to acquire Vanguard, including the assumption of $2.5 billion of Vanguard's net debt.

Use of Estimates

The preparation of financial statements, in conformity with accounting principles generally accepted in the United States of America ("GAAP"), requires us to make estimates and assumptions that affect the amounts reported in our Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Although we believe all adjustments considered necessary for a fair presentation have been included, actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("Compact") and other uninsured discount and charity programs .

Gross charges are retail charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately paid and, therefore, are not displayed in our consolidated statements of operations. Hospitals are typically paid amounts that are negotiated with insurance companies or are set by the government. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts (such as stop-loss payments). Because Medicare requires that a hospital's gross charges be the same for all patients (regardless of payer category), gross charges are also what hospitals charge all other patients prior to the application of discounts and allowances.

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Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as Indirect Medical Education, Direct Graduate Medical Education, disproportionate share hospital and bad debt expense, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded by us could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports generally must be filed within five months after the end of the annual cost reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted. Adjustments for prior-year cost reports and related valuation allowances, principally related to Medicare and Medicaid, increased revenues in the years ended December 31, 2013, 2012 and 2011 by $38 million, $114 million ($81 million related to the industry-wide Medicare Budget Neutrality settlement), and $1 million, respectively. Estimated cost report settlements and valuation allowances are included in accounts receivable in the accompanying Consolidated Balance Sheets (see Note 3). We believe that we have made adequate provision for any adjustments that may result from final determination of amounts earned under all the above arrangements with Medicare and Medicaid.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for these payers and other factors that affect the estimation process.

We know of no material claims, disputes or unsettled matters with any payer that would affect our revenues for which we have not adequately provided for in the accompanying Consolidated Financial Statements.

Under our Compact or other uninsured discount programs, the discount offered to certain uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are financially unable to pay for the health care services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues or in provision for doubtful accounts. Patient advocates from Conifer's Medical Eligibility Program screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs.

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The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Years Ended December 31,		
	2013	2012	2011
General Hospitals:			
Medicare	$ 2,357	$ 2,195	$ 2,068
Medicaid	975	783	802
Managed care	6,277	5,382	5,128
Indemnity, self-pay and other	1,201	1,007	958
Acute care hospitals — other revenue	78	69	105
Other:			
Other operations	1,186	468	310
Net operating revenues before provision for doubtful accounts	**$ 12,074**	**$ 9,904**	**$ 9,371**

Provision for Doubtful Accounts

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Electronic Health Record Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"), federal incentive payments are available to hospitals, physicians and certain other professionals ("Providers") when they adopt, implement or upgrade ("AIU") certified electronic health record ("EHR") technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. Hospitals that are meaningful users under the Medicare EHR incentive payment program are deemed meaningful users under the Medicaid EHR incentive payment program and do not need to meet additional criteria imposed by a state. Medicaid EHR incentive payments to Providers are 100% federally funded and administered by the states. The Centers for Medicare and Medicaid Services ("CMS") established calendar year 2011 as the first year states could offer EHR incentive payments. Before a state may offer EHR incentive payments, the state must submit and CMS must approve the state's incentive plan.

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We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved. During the years ended December 31, 2013, 2012 and 2011, certain of our hospitals and physicians satisfied the CMS AIU and/or meaningful use criteria. As a result, we recognized approximately $96 million, $40 million and $55 million of Medicare and Medicaid EHR incentive payments as a reduction to expense in our Consolidated Statement of Operations for years ended December 31, 2013, 2012 and 2011, respectively.

Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $113 million and $364 million at December 31, 2013 and 2012, respectively. As of December 31, 2013 and 2012, our book overdrafts were approximately $245 million and $232 million, respectively, which were classified as accounts payable.

At December 31, 2013 and 2012, approximately $62 million and $65 million, respectively, of total cash and cash equivalents in the accompanying Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries.

Also at December 31, 2013 and 2012, we had $193 million and $98 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $138 million and $93 million, respectively, were included in accounts payable.

During the years ended December 31, 2013 and 2012, we entered into non-cancellable capital leases of approximately $341 million and $88 million, respectively, primarily for buildings and equipment.

Investments in Debt and Equity Securities

We classify investments in debt and equity securities as either available-for-sale, held-to-maturity or as part of a trading portfolio. At December 31, 2013 and 2012, we had no significant investments in securities classified as either held-to-maturity or trading. We carry securities classified as available-for-sale at fair value. We report their unrealized gains and losses, net of taxes, as accumulated other comprehensive income (loss) unless we determine that a loss is other-than-temporary, at which point we would record a loss in our consolidated statements of operations. We include realized gains or losses in our consolidated statements of operations based on the specific identification method.

Property and Equipment

Additions and improvements to property and equipment exceeding established minimum amounts with a useful life greater than one year are capitalized at cost. Expenditures for maintenance and repairs are charged to expense as incurred. We use the straight-line method of depreciation for buildings, building improvements and equipment. The estimated useful life for buildings and improvements is primarily 15 to 40 years and, for equipment, three to 15 years. Newly constructed hospitals are usually depreciated over 50 years. We record capital leases at the beginning of the lease term as assets and liabilities. The value recorded is the lower of either the present value of the minimum lease payments or the fair value of the asset. Such assets, including improvements, are generally amortized over the shorter of either the lease term or their estimated useful life. Interest costs related to construction projects are capitalized. In the years ended December 31, 2013, 2012 and 2011, capitalized interest was $14 million, $6 million and $8 million, respectively.

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

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We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Asset Retirement Obligations

We recognize the fair value of a liability for legal obligations associated with asset retirements, primarily related to asbestos abatement and costs associated with underground storage tanks, in the period in which it is incurred if a reasonable estimate of the fair value of the obligation can be made. When the liability is initially recorded, we capitalize the cost of the asset retirement obligation by increasing the carrying amount of the related long-lived asset. Over time, the liability is accreted to its present value each period, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in our consolidated statements of operations.

Goodwill and Other Intangible Assets

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances.

Other intangible assets primarily consist of capitalized software costs, which are amortized on a straight-line basis over the estimated useful life of the software, which ranges from three to 15 years. Also included in intangible assets are costs associated with the issuance of our long-term debt, which are primarily being amortized under the effective interest method based on the terms of the specific notes, and miscellaneous intangible assets related to our acquisition of Vanguard.

Accruals for General and Professional Liability Risks

We accrue for estimated professional and general liability claims, when they are probable and can be reasonably estimated. The accrual, which includes an estimate for incurred but not reported claims, is updated each quarter based on an actuarial calculation of projected payments using case-specific facts and circumstances and our historical loss reporting, development and settlement patterns and is discounted to its net present value using a risk-free discount rate (2.45% at December 31, 2013 and 1.18% at December 31, 2012). To the extent that subsequent claims information varies from our estimates, the liability is adjusted in the period such information becomes available. Malpractice expense is presented within other operating expenses in the accompanying Consolidated Statements of Operations.

Income Taxes

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions items requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;

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- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

Segment Reporting

We primarily operate acute care hospitals and related health care facilities. Our general hospitals generated 90.2%, 95.3% and 96.7% of our net operating revenues before provision for doubtful accounts in the years ended December 31, 2013, 2012 and 2011, respectively. Each of our operating regions and markets reports directly to our president of hospital operations. Major decisions, including capital resource allocations, are made at the consolidated level, not at the regional, market or hospital level.

Historically, our business has consisted of one reportable segment, Hospital Operations and other. However, during 2012, our Hospital Operations and other segment and our Conifer subsidiary entered into formal agreements, pursuant to which it was agreed that services provided by both parties to each other would be billed based on estimated third-party pricing terms. As a result, we have presented Conifer as a separate reportable business segment for all periods presented. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Costs Associated With Exit or Disposal Activities

We recognize costs associated with exit (including restructuring) or disposal activities when they are incurred and can be measured at fair value, rather than at the date of a commitment to an exit or disposal plan.

NOTE 2. EQUITY

Reverse Stock Split

On October 11, 2012, our common stock began trading on the New York Stock Exchange on a split-adjusted basis following a one-for-four reverse stock split we announced on October 1, 2012. Every four shares of our issued and outstanding common stock were exchanged for one issued and outstanding share of common stock, without any change in the par value per share, and our authorized shares of common stock were proportionately decreased from 1,050,000,000 shares to 262,500,000 shares. No fractional shares were issued in connection with the stock split. All current and prior period amounts in the accompanying Consolidated Financial Statements and these notes related to shares, share prices and earnings per share have been restated to give retrospective presentation for the reverse stock split.

Share Repurchase Programs

In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase program, we paid approximately $500 million to repurchase a total of 12,891,298 shares during the period from the commencement of the program through December 31, 2013.

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Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
November 1, 2012 through December 31, 2012	**3,406**	**$ 29.36**	**3,406**	**$ 400**
January 1, 2013 through January 31, 2013	531	37.13	531	380
February 1, 2013 through February 28, 2013	914	39.30	914	344
March 1, 2013 through March 31, 2013	1,010	43.95	1,010	300
Three Months Ended March 31, 2013	**2,455**	**40.74**	**2,455**	**300**
May 1, 2013 through May 31, 2013	933	46.78	933	256
June 1, 2013 through June 30, 2013	1,065	45.71	1,065	208
Three Months Ended June 30, 2013	**1,998**	**46.21**	**1,998**	**208**
July 1, 2013 through July 31, 2013	166	46.08	166	200
August 1, 2013 through August 31, 2013	1,045	40.43	1,045	158
September 1, 2013 through September 30, 2013	1,431	40.35	1,431	100
Three Months Ended September 30, 2013	**2,642**	**40.75**	**2,642**	**100**
November 1, 2103 through November 30, 2013	796	42.28	796	66
December 1, 2013 through December 31, 2013	1,594	41.62	1,594	0
Three Months Ended December 31, 2013	**2,390**	**41.84**	**2,390**	**0**
Total	**12,891**	**$ 38.79**	**12,891**	**$ 0**

Repurchased shares are recorded based on settlement date and are held as treasury stock.

Mandatory Convertible Preferred Stock

In April 2012, we repurchased and subsequently retired 298,700 shares of our 7% mandatory convertible preferred stock with a carrying value of $289 million. In a related private financing, we issued an additional $141 million aggregate principal amount of our 6 1/4% senior secured notes due 2018 at a premium for $142 million of cash proceeds and an additional $150 million aggregate principal amount of our 8% senior notes due 2020. We recorded the difference between the carrying value and the amount paid to redeem the preferred stock in April 2012 as preferred stock dividends in the accompanying Consolidated Statements of Operations. On October 1, 2012, the remaining 46,300 shares outstanding of our mandatory convertible preferred stock automatically converted to 1,978,633 shares of our common stock. We accrued approximately $6 million, or $17.50 per share, for dividends on the preferred stock in the three months ended March 31, 2012 and $1 million in each of the three months ended June 30, 2012 and September 30, 2012, and paid the dividends in April, July and October 2012, respectively.

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Changes in Redeemable Noncontrolling Interests in Equity of Consolidated Subsidiaries

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the year ended December 31, 2013 and 2012:

	Year Ended December 31,	
	2013	2012
Balances at beginning of period	**$ 16**	**$ 16**
Net income	9	0
Distributions paid to noncontrolling interests	(5)	0
Sales of joint venture interests	52	0
Purchases of businesses	175	0
Balances at end of period	**$ 247**	**$ 16**

As part of the acquisition of Vanguard, we obtained a 51% controlling interest in a partnership that held the assets and liabilities of Valley Baptist Health System ("Valley Baptist"). The remaining 49% non-controlling interest is held by the former owner of Valley Baptist (the "seller"). The partnership operating agreement includes a put option that the seller may exercise on its 49% non-controlling interest upon either the third or fifth anniversary, September 1, 2014 and September 1, 2016, respectively, of the transaction date. The redemption value is calculated based upon the operating results and the debt of the partnership, but is subject to a floor value. We also have the option to call a stated percentage of the seller's non-controlling interest in the event the seller does not exercise its put option on either of the anniversary dates. The carrying value of the redeemable noncontrolling interest in Valley Baptist has been determined based upon the calculated acquisition date fair value of the seller's interest in the partnership, such fair value based upon Level 3 (consistent with the value methodologies for Level 3 described in Note 18) estimates of future operating results of the partnership, plus the seller's portion of the partnership earnings during the three months ended December 31, 2013. If the seller exercises its put option, we may purchase the non-controlling interest with cash or by issuing stock.

NOTE 3. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

The principal components of accounts receivable are shown in the table below:

	December 31,	
	2013	2012
Continuing operations:		
Patient accounts receivable	$ 2,537	$ 1,668
Allowance for doubtful accounts	(589)	(396)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	91	88
Net cost report settlements payable and valuation allowances	(4)	(24)
	2,035	1,336
Discontinued operations:		
Patient accounts receivable	1	11
Allowance for doubtful accounts	0	(5)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	0	2
Net cost report settlements receivable and valuation allowances	2	1
	3	9
Accounts receivable, net	**$ 2,038**	**$ 1,345**

As of December 31, 2013 and 2012, our allowance for doubtful accounts was 23.2% and 23.7%, respectively, of our patient accounts receivable. Accounts that are pursued for collection through the regional business offices of Conifer are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. As of December 31, 2013 and 2012, our allowance for doubtful accounts for self-pay was 75.9% and 73.8%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. As of December 31, 2013 and 2012, our allowance for doubtful accounts for managed care was 5.6% and 9.4%, respectively, of our managed care patient accounts receivable. During the year ended December 31, 2013, we experienced a significant change in the overall composition of our patient accounts receivable due to the acquisition of Vanguard in October 2013.

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Accounts assigned to our Conifer subsidiary are written off and excluded from patient accounts receivable and allowance for doubtful accounts; however, an estimate of future recoveries from all accounts at our Conifer subsidiary is determined based on historical experience and recorded on our hospitals' books as a component of accounts receivable in the accompanying Consolidated Balance Sheets. At the present time, our new acquisitions have not been fully integrated into our Conifer collections processes.

The estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the years ended December 31, 2013, 2012 and 2011 were approximately $545 million, $430 million and $379 million, respectively. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the years ended December 31, 2013, 2012 and 2011 were approximately $158 million, $136 million, and $113 million, respectively. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the years ended December 31, 2013, 2012 and 2011 were approximately $428 million, $283 million and $255 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues.

NOTE 4. DISCONTINUED OPERATIONS

In the year ended December 31, 2013, we recognized a $12 million gain in discontinued operations related to the sale of land.

In the three months ended June 30, 2012, our Creighton University Medical Center hospital ("CUMC") in Nebraska was reclassified into discontinued operations based on the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," as a result of our plan to sell CUMC. We recorded an impairment charge in discontinued operations of $100 million, consisting of $98 million for the write-down of CUMC's long-lived assets to their estimated fair values, less estimated costs to sell, and a $2 million charge for the write-down of goodwill related to CUMC in the three months ended June 30, 2012. We completed the sale of CUMC on August 31, 2012 at a transaction price of $40 million, excluding working capital, and recognized a loss on sale of approximately $1 million in discontinued operations. Because we did not sell the accounts receivable of CUMC, net receivables of approximately $9 million are included in our accounts receivable in the accompanying Consolidated Balance Sheet at December 31, 2012.

In May 2012, we completed the sale of Diagnostic Imaging Services, Inc. ("DIS"), our former diagnostic imaging center business in Louisiana, for net proceeds of approximately $10 million. As a result of the sale, DIS was reclassified into discontinued operations in the three months ended June 30, 2012, and a gain on sale of approximately $2 million was recognized in discontinued operations.

We recorded a $6 million impairment charge in discontinued operations during the year ended December 31, 2011 for the write-down of goodwill related to DIS. Material adverse trends in our estimates of future operating results of the centers at that time, primarily due to our limited market presence, indicated that the carrying value of the goodwill exceeded its fair value. As a result, we reduced the carrying value of the goodwill to its fair value as determined based on an appraisal.

Net operating revenues and loss before income taxes reported in discontinued operations are as follows:

	Years Ended December 31,		
	2013	2012	2011
Net operating revenues	$ 7	$ 154	$ 216
Loss before income taxes	(7)	(101)	(41)

Included in loss before income taxes from discontinued operations in the year ended December 31, 2011 is approximately $14 million of expense related to the settlement of two Hurricane Katrina-related class action lawsuits, which amount is net of approximately $10 million of recoveries from our reinsurance carriers in connection with the settlement. We had previously recorded a $5 million reserve for this matter as of December 31, 2010. Also included in loss before income taxes from discontinued operations in the year ended December 31, 2011 is approximately $17 million of expense recorded in litigation and investigation costs allocable to certain of our previously divested hospitals related to changes in the reserve estimate established in connection with a governmental review and an accrual for a hospital-related tort claim.

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Should we dispose of additional hospitals or other assets in the future, we may incur additional asset impairment and restructuring charges in future periods.

NOTE 5. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

We recognized impairment charges on long-lived assets in 2013, 2012 and 2011 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in health care industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

As of December 31, 2013, our continuing operations consisted of two operating segments, our hospital and other operations and our Conifer subsidiary. In the three months ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard, and we moved our hospitals in Philadelphia, Pennsylvania from our Southern States region into our Northeast region. Our hospital and other operations segment was structured as follows as of December 31, 2013:

- Our California region included all of our hospitals and other operations in California;
- Our Central region included all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the San Antonio or South Texas markets;
- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern States region included all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;
- Our Detroit market region included all of our hospitals and other operations in the Detroit, Michigan area;
- Our Phoenix market included all of our hospitals and other operations in the Phoenix, Arizona area;
- Our San Antonio market included all of our hospitals and other operations in the San Antonio, Texas area; and
- Our South Texas market included all of our hospitals and other operations in the Brownsville, Texas and Harlingen, Texas areas.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our statement of operations as they are incurred. Our restructuring plans focus on various aspects of operations, including aligning our operations in the most strategic and cost-effective structure. Certain restructuring and acquisition-related costs are based upon estimates. Changes in estimates are recognized as they occur.

Year Ended December 31, 2013

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and

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other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment continues to decline. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination costs, and $59 million in acquisition-related costs, which includes both transaction costs and acquisition integration charges.

Year Ended December 31, 2012

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of $19 million, consisting of $3 million relating to the impairment of obsolete assets, $2 million relating to other impairment charges, $8 million of employee severance costs and $6 million of other related costs.

Year Ended December 31, 2011

During the year ended December 31, 2011, we recorded net impairment and restructuring charges of $20 million. This amount included a $6 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors contributing to the adverse financial trends at that time included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $20 million as of December 31, 2011 after recording the impairment charge. In addition, we also recorded impairment charges of $1 million in connection with the sale of seven medical office buildings in Texas, $1 million related to a cost basis investment, $7 million in employee severance costs, $3 million in lease termination costs, $1 million of acceleration of stock-based compensation costs and $1 million of other related costs.

NOTE 6. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of December 31, 2013 and 2012:

	December 31, 2013	December 31, 2012
Senior notes:		
7 3/8%, due 2013	$ 0	$ 55
9 7/8%, due 2014	60	60
9 1/4%, due 2015	474	474
6 3/4%, due 2020	300	300
8%, due 2020	750	750
8 1/8%, due 2022	2,800	0
6 7/8%, due 2031	430	430
Senior secured notes:		
6 1/4%, due 2018	1,041	1,041
10%, due 2018	0	714
8 7/8%, due 2019	0	925
4 3/4%, due 2020	500	500
6%, due 2020	1,800	0
4 1/2%, due 2021	850	0
4 3/8%, due 2021	1,050	0
Credit facility due 2016	405	0
Capital leases and mortgage notes	407	119
Unamortized note discounts and premium	(28)	(116)
Total long-term debt	**10,839**	**5,252**
Less current portion	149	94
Long-term debt, net of current portion	**$ 10,690**	**$ 5,158**

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Credit Agreement

We have a senior secured revolving credit facility (as amended, "Credit Agreement"), that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016, subject to our repayment or refinancing on or before November 3, 2014 of approximately $238 million of the aggregate outstanding principal amount of our 9 1/4% senior notes due 2015 (approximately $474 million of which was outstanding at December 31, 2013). If such repayment or refinancing does not occur, borrowings under the Credit Agreement will be due November 3, 2014. The revolving credit facility is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. In addition, borrowings under the Credit Agreement are guaranteed by our wholly owned hospital subsidiaries. Outstanding revolving loans accrued interest during a six-month initial period that ended in May 2012 at the rate of either (i) a base rate plus a margin of 1.25% or (ii) the London Interbank Offered Rate ("LIBOR") plus a margin of 2.25% per annum. Outstanding revolving loans now accrue interest at a base rate plus a margin ranging from 1.00% to 1.50% or LIBOR plus a margin ranging from 2.00% to 2.50% per annum based on available credit. An unused commitment fee was payable on the undrawn portion of the revolving loans at a six-month initial rate that ended in May 2012 of 0.438% per annum. The unused commitment fee now ranges from 0.375% to 0.500% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At December 31, 2013, we had $405 million of cash borrowings outstanding under the revolving credit facility subject to an interest rate of 2.38%, and we had approximately $189 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $406 million was available for borrowing under the revolving credit facility at December 31, 2013.

Senior Notes and Senior Secured Notes

In October 2013, we sold $2.8 billion aggregate principal amount of 8 1/8% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8 1/8% senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard.

In May 2013, we sold $1.050 billion aggregate principal amount of 4 3/8% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4 3/8% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, commencing on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately $767 million aggregate principal amount outstanding of our 8 7/8% senior secured notes due 2019 in a tender offer and to call approximately $158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold $850 million aggregate principal amount of 4 1/2% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4 1/2% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately $645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately $69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $177 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs. The remaining net proceeds were used for general corporate purposes, including the repayment of borrowings under our senior secured revolving credit facility.

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In October 2012, we sold $500 million aggregate principal amount of 4 3/4% senior secured notes due 2020 and $300 million aggregate principal amount of 6 3/4% senior notes due 2020. The 4 3/4% senior secured notes will mature on June 1, 2020, and the 6 3/4% senior notes will mature on February 1, 2020. We will pay interest on the 4 3/4% senior secured notes semi-annually in arrears on June 1 and December 1 of each year, commencing on June 1, 2013. We will pay interest on the 6 3/4% senior notes semi-annually in arrears on February 1 and August 1 of each year; payments commenced on February 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase $161 million aggregate principal amount outstanding of our 7 3/8% senior notes due 2013 in a tender offer. In connection with the purchase, we recorded a loss from early extinguishment of debt of approximately $4 million primarily related to the difference between the purchase prices and the par values of the purchased notes.

In April 2012, we issued an additional $141 million aggregate principal amount of our 6 1/4% senior secured notes due 2018 at a premium for $142 million of cash proceeds and an additional $150 million aggregate principal amount of our 8% senior notes due 2020 in a private financing related to our repurchase and subsequent retirement of 298,700 shares of our 7% mandatory convertible preferred stock.

All of our senior notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to our senior secured notes described below, the obligations of our subsidiaries and any obligations under our Credit Agreement to the extent of the collateral. We may redeem any series of our senior notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed, plus a make-whole premium specified in the applicable indenture, together with accrued and unpaid interest to the redemption date.

All of our senior secured notes are guaranteed by our wholly owned hospital company subsidiaries and secured by a first-priority pledge of the capital stock and other ownership interests of those subsidiaries. All of our senior secured notes and the related subsidiary guarantees are our and the subsidiary guarantors' senior secured obligations. All of our senior secured notes rank equally in right of payment with all of our other senior secured indebtedness. Our senior secured notes rank senior to any subordinated indebtedness that we or such subsidiary guarantors may incur; they are effectively senior to our and such subsidiary guarantors' existing and future unsecured indebtedness and other liabilities to the extent of the value of the collateral securing the notes and the subsidiary guarantees; they are effectively subordinated to our and such subsidiary guarantors' obligations under our Credit Agreement to the extent of the value of the collateral securing borrowings thereunder; and they are structurally subordinated to all obligations of our non-guarantor subsidiaries.

The indentures setting forth the terms of our senior secured notes contain provisions governing our ability to redeem the notes and the terms by which we may do so. At our option, we may redeem our 4 3/4% senior secured notes and our 6 1/4% senior secured notes, in whole or in part, at any time at a redemption price equal to 100% of the principal amount of the notes redeemed plus the make-whole premium set forth in the related indenture, together with accrued and unpaid interest thereon, if any, to the redemption date. In addition, we, at our option, may redeem our 8 7/8% and 10% senior secured notes, in whole or in part, or on or prior to July 1, 2014 in the case of the 8 7/8% senior secured notes and May 1, 2014 in the case of the 10% senior secured notes, at a redemption price equal to 100% of the principal amount of the notes redeemed plus the applicable make-whole premium set forth in the applicable indenture, together with accrued and unpaid interest thereon, if any, to the redemption date. At any time or from time to time after July 1, 2014 in the case of the 8 7/8% senior secured notes and May 1, 2014 in the case of the 10% senior secured notes, we, at our option, may redeem the notes, in whole or in part, at the redemption prices set forth in the applicable indenture, together with accrued and unpaid interest thereon, if any, to the redemption date.

In addition, we may be required to purchase for cash all or any part of each series of our senior secured notes upon the occurrence of a change of control (as defined in the applicable indentures) for a cash purchase price of 101% of the aggregate principal amount of the notes, plus accrued and unpaid interest.

Covenants

Our Credit Agreement contains customary covenants for an asset-backed facility, including a minimum fixed charge coverage ratio to be met when the available credit under the revolving credit facility falls below $80 million, as well as limits on debt, asset sales and prepayments of senior debt. The Credit Agreement also includes a provision, which we believe is customary in receivables-backed credit facilities, that gives our banks the right to require that proceeds of collections of substantially all of our consolidated accounts receivable be applied directly to repay outstanding loans and other amounts that are due and payable under the Credit Agreement at any time that unused borrowing availability under the revolving credit facility is less than $100 million or if an event of default has occurred and is continuing thereunder. In that event, we would seek to re-borrow under

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the Credit Agreement to satisfy our operating cash requirements. Our ability to borrow under the Credit Agreement is subject to conditions that we believe are customary in revolving credit facilities, including that no events of default then exist.

The indentures governing our senior notes contain covenants and conditions that have, among other requirements, limitations on (1) liens on principal properties and (2) sale and lease-back transactions with respect to principal properties. A principal property is defined in the indentures as a hospital that has an asset value on our books in excess of 5% of our consolidated net tangible assets, as defined. The above limitations do not apply, however, to (1) debt that is not secured by principal properties or (2) debt that is secured by principal properties if the aggregate of such secured debt does not exceed 15% of our consolidated net tangible assets, as further described in the indentures. The indentures also prohibit the consolidation, merger or sale of all or substantially all assets unless no event of default would result after giving effect to such transaction.

The indentures governing our senior secured notes contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions or consolidate, merge or sell all or substantially all of our or their assets, other than in certain transactions between one or more of our wholly owned subsidiaries. These restrictions, however, are subject to a number of important exceptions and qualifications. In particular, there are no restrictions on our ability or the ability of our subsidiaries to incur additional indebtedness, make restricted payments, pay dividends or make distributions in respect of capital stock, purchase or redeem capital stock, enter into transactions with affiliates or make advances to, or invest in, other entities (including unaffiliated entities). In addition, the indentures governing our senior secured notes contain a covenant that neither we nor any of our subsidiaries will incur secured debt, unless at the time of and after giving effect to the incurrence of such debt, the aggregate amount of all such secured debt (including the aggregate principal amount of senior secured notes outstanding at such time) does not exceed the greater of (i) $3.2 billion or (ii) the amount that would cause the secured debt ratio (as defined in the indentures) to exceed 4.0 to 1.0; provided that the aggregate amount of all such debt secured by a lien on par to the lien securing the senior secured notes may not exceed the greater of (a) $2.6 billion or (b) the amount that would cause the secured debt ratio to exceed 3.0 to 1.0.

Future Maturities

Future long-term debt maturities and minimum operating lease payments as of December 31, 2013 are as follows:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Long-term debt, including capital lease obligations	$ 10,867	$ 149	$ 539	$ 430	$ 49	$ 1,047	$ 8,653
Long-term non-cancelable operating leases	$ 663	$ 137	$ 117	$ 102	$ 80	$ 56	$ 171

Rental expense under operating leases, including short-term leases, was $186 million, $156 million and $143 million in the years ended December 31, 2013, 2012 and 2011, respectively. Included in rental expense for each of these periods was sublease income of $8 million, which were recorded as a reduction to rental expense.

NOTE 7. GUARANTEES

Consistent with our policy on physician relocation and recruitment, we provide income guarantee agreements to certain physicians who agree to relocate to fill a community need in the service area of one of our hospitals and commit to remain in practice in the area for a specified period of time. Under such agreements, we are required to make payments to the physicians in excess of the amounts they earn in their practices up to the amount of the income guarantee. The income guarantee periods are typically 12 months. If a physician does not fulfill his or her commitment period to the community, which is typically three years subsequent to the guarantee period, we seek recovery of the income guarantee payments from the physician on a prorated basis. We also provide revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals with terms generally ranging from one to three years.

At December 31, 2013, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $108 million. We had a liability of $78 million recorded for these guarantees included in other current liabilities at December 31, 2013.

We have also guaranteed minimum rent revenue to certain landlords who built medical office buildings on or near our hospital campuses. The maximum potential amount of future payments under these guarantees at December 31, 2013 was $16 million. We had a liability of $2 million recorded for these guarantees at December 31, 2013, of which $1 million was included in other current liabilities and $1 million was included in other long-term liabilities.

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NOTE 8. EMPLOYEE BENEFIT PLANS

Share-Based Compensation Plans

We currently grant stock-based awards to our directors and key employees pursuant to our 2008 Stock Incentive Plan, which was approved by our shareholders at their 2008 annual meeting. At December 31, 2013, approximately 2.1 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, from time to time, we grant performance-based options and restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe.

Our income from continuing operations for the years ended December 31, 2013, 2012 and 2011 includes $39 million, $33 million and $25 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements ($24 million, $21 million and $15 million, respectively, after-tax, excluding the impact of the deferred tax valuation allowance). The table below shows certain stock option and restricted stock unit grants and other awards that comprise the $37 million of stock-based compensation expense recorded in salaries, wages and benefits in the year ended December 31, 2013. Compensation cost is measured by the fair value of the awards on their grant dates and is recognized over the requisite service period of the awards, whether or not the awards had any intrinsic value during the period.

Grant Date	Awards	Exercise Price Per Share	Fair Value Per Share at Grant Date	Stock-Based Compensation Expense for Year Ended December 31, 2013
	(In Thousands)			(In Millions)
Stock Options:				
February 28, 2013	266	$ 39.31	$ 14.46	$ 1
February 29, 2012	355	$ 22.60	11.96	2
Restricted Stock Units:				
October 31, 2013	178		47.19	1
June 13, 2013	318		47.13	1
May 6, 2013	30		47.00(1)	1
February 28, 2013	841		39.31	7
February 29, 2012	987		22.60	6
January 31, 2012	64		21.16	2
November 4, 2011	60		19.44(1)	1
February 23, 2011	890		27.60	9
Other grants				6
				$ 37

(1) End of month fair market value was used for this grant to calculate compensation expense.

Prior to our shareholders approving the 2008 Stock Incentive Plan, we granted stock-based awards to our directors and employees pursuant to other plans. Stock options remain outstanding under those other plans, but no additional stock-based awards will be granted under them.

Pursuant to the terms of our stock-based compensation plans, awards granted under the plans vest and may be exercised as determined by the compensation committee of our board of directors. In the event of a change in control, the compensation committee may, at its sole discretion without obtaining shareholder approval, accelerate the vesting or performance periods of the awards.

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Stock Options

The following table summarizes stock option activity during the years ended December 31, 2013, 2012 and 2011:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding as of December 31, 2010	10,788,887	39.88		
Granted	0			
Exercised	(629,021)	5.24		
Forfeited/Expired	(1,661,473)	128.92		
Outstanding as of December 31, 2011	8,498,393	25.04		
Granted	477,500	22.79		
Exercised	(3,657,127)	5.77		
Forfeited/Expired	(1,029,574)	69.72		
Outstanding as of December 31, 2012	4,289,192	30.49		
Granted	295,639	39.41		
Exercised	(946,086)	23.34		
Forfeited/Expired	(330,634)	55.79		
Outstanding as of December 31, 2013	**3,308,111**	**$ 30.79**	**$ 41**	**3.3 years**
Vested and expected to vest at December 31, 2013	**3,294,282**	**$ 30.76**	**$ 41**	**3.3 years**
Exercisable as of December 31, 2013	**2,776,320**	**$ 30.66**	**$ 36**	**2.8 years**

There were 946,086 stock options exercised during the year ended December 31, 2013 with a $18 million aggregate intrinsic value, and 3,657,127 stock options exercised in 2012 with a $71 million aggregate intrinsic value.

As of December 31, 2013, there were $4 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 1.7 years.

In the year ended December 31, 2013, we granted an aggregate of 295,639 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. These stock options will all vest on the third anniversary of the grant date, subject to the terms of the plan, and will expire on the fifth anniversary of the grant date. In the year ended December 31, 2012, we granted an aggregate of 477,500 stock options under our 2008 Stock Incentive Plan to certain of our senior officers; 257,500 of these stock options are subject to time-vesting and 220,000 of these stock options were granted subject to performance-based vesting. Because all conditions were met, the performance-based options will vest and be settled ratably over a three-year period from the grant date.

The weighted average estimated fair value of stock options we granted in the year ended December 31, 2013 and 2012 was $14.46 and $12.05 per share, respectively. These fair values were calculated based on each grant date, using a binomial lattice model with the following assumptions:

	Year Ended December 31,	
	2013	2012
Expected volatility	50%	52%
Expected dividend yield	0%	0%
Expected life	3.6 years	6.9 years
Expected forfeiture rate	6%	2%
Risk-free interest rate	0.48%	1.06%-1.41%
Early exercise threshold	100% gain	70% gain
Early exercise rate	50% per year	20% per year

The expected volatility used in the binomial lattice model incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price on two dates (one in 2010 and one in 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from the output of the binomial lattice model and represents the period of time that the options

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are expected to be outstanding. This model incorporates an early exercise assumption in the event of a significant increase in stock price. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise timeframes.

The following table summarizes information about our outstanding stock options at December 31, 2013:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	324,542	5.1 years	$ 4.56	324,542	$ 4.56
$4.57 to $25.089	1,027,963	5.9 years	20.83	774,623	20.17
$25.09 to $32.569	518,804	2.5 years	29.64	518,804	29.64
$32.57 to $42.529	798,781	2.2 years	41.17	520,330	42.17
$42.53 to $55.129	638,021	0.2 years	48.11	638,021	48.11
	3,308,111	**3.3 years**	**$ 30.79**	**2,776,320**	**$ 30.66**

As of December 31, 2013, approximately 78.9% of our outstanding options were held by current employees and approximately 21.1% were held by former employees. Approximately 77.2% of our outstanding options were in-the-money, that is, they had an exercise price less than the $42.12 market price of our common stock on December 31, 2013, and approximately 22.8% were out-of-the-money, that is, they had an exercise price of more than $42.12 as shown in the table below:

	In-the-Money Options		Out-of-the-Money Options		All Options	
	Outstanding	% of Total	Outstanding	% of Total	Outstanding	% of Total
Current employees	2,177,530	85.3%	433,841	57.4%	2,611,371	78.9%
Former employees	375,227	14.7%	321,513	42.6%	696,740	21.1%
Totals	2,552,757	100.0%	755,354	100.0%	3,308,111	100.0%
% of all outstanding options	77.2%		22.8%		100.0%	

Restricted Stock Units

The following table summarizes restricted stock unit activity during the years ended December 31, 2013, 2012 and 2011:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested as of December 31, 2010	1,580,318	20.56
Granted	1,138,350	27.04
Vested	(722,471)	19.92
Forfeited	(68,890)	23.72
Unvested as of December 31, 2011	1,927,307	24.52
Granted	1,654,337	22.18
Vested	(1,033,632)	23.51
Forfeited	(252,070)	23.39
Unvested as of December 31, 2012	2,295,942	23.40
Granted	1,564,224	41.20
Vested	(966,838)	24.20
Forfeited	(186,106)	29.69
Unvested as of December 31, 2013	**2,707,222**	**$ 33.34**

In the year ended December 31, 2013, we granted 1,122,811 restricted stock units subject to time-vesting, of which 1,023,112 will vest and be settled ratably over a three-year period from the date of the grant, 80,133 will vest 100% on the fifth anniversary of the grant date and 19,566 will vest 100% on the third anniversary of the grant date. In addition, we granted 206,058 performance-based restricted stock units to certain of our senior officers. If all conditions are met, the performance-based restricted stock units will vest and be settled ratably over a three-year period from the grant date. We also awarded a grant of 23,175 performance-based restricted stock units to one of our senior executives. If target conditions are met, 100% of this grant will vest and be settled three years from the grant date. We also awarded a grant of 212,180 restricted stock units to our chief executive officer, of which 106,090 are subject to time-vesting and 106,090 are performance-based. If target conditions are met, 50% of this grant will vest three years from the grant date and the remaining 50% will vest six years from the grant date. The award also allows for an additional 106,090 shares to be issued if higher performance criteria are met. In the year ended

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December 31, 2012, we granted 1,538,082 restricted units subject to time-vesting. In addition, we granted 116,255 performance-based restricted stock units to certain of our senior officers. Because all conditions were met, the performance-based restricted stock units will vest and be settled ratably over a three-year period from the grant date.

As of December 31, 2013, there were $63 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.9 years.

Employee Stock Purchase Plan

We have an employee stock purchase plan under which we are currently authorized to issue up to 5,062,500 shares of common stock to our eligible employees. As of December 31, 2013, there were approximately 405,381 shares available for issuance under our employee stock purchase plan. Under the terms of the plan, eligible employees may elect to have between 1% and 10% of their base earnings withheld each quarter to purchase shares of our common stock. Shares are purchased at a price equal to 95% of the closing price on the last day of the quarter. The plan requires a one-year holding period for all shares issued. The holding period does not apply upon termination of employment. Under the plan, no individual may purchase, in any year, shares with a fair market value in excess of $25,000. The plan is currently not considered to be compensatory.

We sold the following numbers of shares under our employee stock purchase plan in the years ended December 31, 2013, 2012 and 2011:

	Years Ended December 31,		
	2013	2012	2011
Number of shares	100,217	144,021	187,409
Weighted average price	$ 42.88	$ 22.81	$ 21.44

Employee Retirement Plans

Substantially all of our employees, upon qualification, are eligible to participate in one of our defined contribution 401(k) plans. Under the plans, employees may contribute a portion of their eligible compensation, and we match such contributions annually up to a maximum percentage for participants actively employed, as defined by the plan documents. Employer matching contributions will vary by plan. Plan expenses, primarily related to our contributions to the plan, were approximately $35 million, $32 million and $32 million for the years ended December 31, 2013, 2012 and 2011, respectively. Such amounts are reflected in salaries, wages and benefits in the accompanying Consolidated Statements of Operations.

We maintain one active and two frozen non-qualified defined benefit pension plans ("SERPs") that provide supplemental retirement benefits to certain of our current and former executives. These plans are not funded, and plan obligations for these plans are paid from our working capital. Pension benefits are generally based on years of service and compensation. Upon completing the acquisition of Vanguard on October 1, 2013, we assumed a frozen qualified defined benefit plan ("DMC Pension Plan") covering substantially all of the employees of our Detroit market that were hired prior to June 1, 2003. The benefits paid under the DMC Pension Plan are primarily based on years of service and final average earnings. The following tables summarize the balance sheet impact, as well as the benefit obligations, funded status and rate assumptions associated with the SERPs and the DMC Pension Plan based on actuarial valuations prepared as of December 31, 2013 and 2012:

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	December 31, 2013	December 31, 2012
Reconciliation of funded status of plans and the amounts included in the Consolidated Balance Sheets:		
Projected benefit obligations(1)		
Beginning obligations	$ (312)	$ (285)
Assumed from acquisition	(1,037)	(0)
Service cost	(2)	(2)
Interest cost	(25)	(14)
Actuarial gain(loss)	44	(30)
Plan changes	(2)	(0)
Benefits paid/employer contributions	31	19
Ending obligations	(1,303)	(312)
Fair value of plans assets		
Beginning obligations	(0)	(0)
Assumed from acquisition	863	(0)
Gain on plan assets	34	(0)
Benefits paid	(11)	(0)
Ending plan assets	886	(0)
Funded status of plans	$ (417)	$ (312)
Amounts recognized in the Consolidated Balance Sheets consist of:		
Other current liability	$ (19)	$ (20)
Other long-term liability	(398)	(292)
Accumulated other comprehensive loss	22	90
	$ (395)	$ (222)
SERP Assumptions:		
Discount rate	5.00%	4.00%
Compensation increase rate	3.00%	3.00%
Measurement date	December 31, 2013	December 31, 2012
DMC Pension Plan Assumptions:		
Discount rate	5.18%	n/a
Compensation increase rate	Frozen	n/a
Measurement date	December 31, 2013	n/a

(1) The accumulated benefit obligation at December 31, 2013 and 2012 was approximately $1,297 million and $308 million, respectively.

The components of net periodic benefit costs and related assumptions are as follows:

	Years Ended December 31, 2013	2012	2011
Service costs	$ 2	$ 2	$ 2
Interest costs	25	14	14
Amortization of prior-year service costs	(15)	0	0
Amortization of net actuarial loss	7	5	3
Net periodic benefit cost	$ 19	$ 21	$ 19
SERP Assumptions:			
Discount rate	4.00%	5.00%	5.50%
Long-term rate of return on assets	n/a	n/a	n/a
Compensation increase rate	3.00%	3.00%	3.00%
Measurement date	January 1, 2013	January 1, 2012	January 1, 2011
Census date	January 1, 2013	January 1, 2012	January 1, 2011
DMC Pension Plan Assumptions:			
Discount rate	5.01%	n/a	n/a
Long-term rate of return on assets	7.00%	n/a	n/a
Compensation increase rate	Frozen	n/a	n/a
Measurement date	October 1, 2013	n/a	n/a
Census date	January 1, 2013	n/a	n/a

Net periodic benefit costs for the current year are based on assumptions determined at the valuation date of the prior year for the SERPs and at the date of acquisition for the DMC Pension Plan.

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We recorded gain/(loss) adjustments of $68 million, ($25) million and ($15) million in other comprehensive income (loss) in the years ended December 31, 2013, 2012 and 2011, respectively, to recognize changes in the funded status of our SERPs and the DMC Pension Plan. Changes in the funded status are recorded as a direct increase or decrease to shareholders' equity through accumulated other comprehensive loss. Net actuarial gains/(losses) of $63 million, ($30) million and ($19) million during the years ended December 31, 2013, 2012 and 2011, respectively, and the amortization of net prior service costs of less than $1 million for the years ended December 31, 2013, 2012 and 2011 were recognized in other comprehensive income (loss). Cumulative net actuarial losses of $21 million, $90 million and $65 million as of December 31, 2013, 2012 and 2011, respectively, and unrecognized prior service costs of less than $1 million as of each of the years ended December 31, 2013, 2012 and 2011, have not yet been recognized as components of net periodic benefit costs.

To develop the expected long-term rate of return on plan assets assumption, the DMC Pension Plan considers the current level of expected returns on risk-free investments (primarily government bonds), the historical level of risk premium associated with the other asset classes in which the portfolio is invested and the expectations for future returns on each asset class. The expected return for each asset class is then weighted based on the target asset allocation to develop the expected long-term rate of return on assets assumption for the portfolio. The weighted-average asset allocations by asset category as of December 31, 2013, were as follows:

Asset Category	Target	Actual
Cash and cash equivalents	6%	6%
United States government obligations	1%	1%
Equity securities	45%	51%
Debt Securities	48%	42%

The DMC Pension Plan assets are invested in separately managed portfolios using investment management firms. The objective for all asset categories is to maximize total return without assuming undue risk exposure. The DMC Pension Plan maintains a well-diversified asset allocation that best meets these objectives. The DMC Pension Plan assets are largely comprised of equity securities, which include companies with various market capitalization sizes in addition to international and convertible securities. Cash and cash equivalents are comprised of money market funds. Debt securities include domestic and foreign government obligations, corporate bonds, and mortgage-backed securities. Under the investment policy of the DMC Pension Plan, investments in derivative securities are not permitted for the sole purpose of speculating on the direction of market interest rates. Included in this prohibition are leveraging, shorting, swaps, futures, options, forwards, and similar strategies.

In each investment account, the DMC Pension Plan investment managers are responsible to monitor and react to economic indicators, such as gross domestic product, consumer price index and U.S. monetary policy that may affect the performance of their account. The performance of all managers and the aggregate asset allocation are formally reviewed on a quarterly basis, with a rebalancing of the asset allocation occurring at least once a year. The current asset allocation objective is to maintain a certain percentage with each class allowing for a 10% deviation from the target.

The following tables summarize the DMC Pension Plan assets measured at fair value on a recurring basis as of December 31, 2013, aggregated by the level in the fair value hierarchy within which those measurements are determined. Fair value methodologies for Level 1, Level 2 and Level 3 are consistent with the inputs described in Note 18.

	December 31, 2013	(Level 1)	(Level 2)	(Level 3)
Cash and cash equivalents	$ 53	$ 53	$ —	$ —
United States government obligations	5	5	—	—
Corporate bonds	376	376	—	—
Equity securities	452	452	—	—
	$ 886	$ 886	$ —	$ —

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The following table presents the estimated future benefit payments to be made from the SERPs and the DMC Pension Plan, a portion of which will be funded from plan assets, for the next five years and in the aggregate for the five years thereafter:

	Total	Years Ending December 31, 2014	2015	2016	2017	2018	Five Years Thereafter
Estimated benefit payments	$ 841	$ 88	$ 74	$ 76	$ 80	$ 82	$ 441

The SERP and DMC Pension Plan obligations of $417 million at December 31, 2013 are classified in the accompanying Consolidated Balance Sheet as an other current liability ($19 million) and defined benefit plan obligations ($398 million) based on an estimate of the expected payment patterns. We expect to make total contributions to the plans of approximately $28 million for the year ending December 31, 2014.

NOTE 9. CAPITAL COMMITMENTS

In connection with Vanguard's acquisition of Detroit Medical Center, certain capital commitments were agreed upon to be satisfied at particular dates. If these commitments are not met by these required dates, we are required to escrow cash for the purpose of funding certain capital projects. There was no required escrow balance as of December 31, 2013.

NOTE 10. PROPERTY AND EQUIPMENT

The principal components of property and equipment are shown in the table below:

	December 31, 2013	2012
Land	$ 589	$ 341
Buildings and improvements	6,369	4,087
Construction in progress	593	140
Equipment	4,038	3,219
	11,589	7,787
Accumulated depreciation and amortization	(3,898)	(3,494)
Net property and equipment	**$ 7,691**	**$ 4,293**

Property and equipment is stated at cost, less accumulated depreciation and amortization and impairment write-downs related to assets held and used.

NOTE 11. GOODWILL AND OTHER INTANGIBLE ASSETS

The following table provides information on changes in the carrying amount of goodwill, which is included in the accompanying Consolidated Balance Sheets as of December 31, 2013 and 2012:

	2013	2012
Hospital Operations and other		
As of January 1:		
Goodwill	$ 3,268	$ 3,166
Accumulated impairment losses	(2,430)	(2,430)
Total	838	736
Goodwill acquired during the year and purchase price allocation adjustments	2,121	104
Goodwill allocated to hospital sold	(0)	(2)
Impairment of goodwill	0	0
Total	**$ 2,959**	**$ 838**
As of December 31:		
Goodwill	$ 5,389	$ 3,268
Accumulated impairment losses	(2,430)	(2,430)
Total	**$ 2,959**	**$ 838**

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	2013	2012
Conifer		
As of January 1:		
Goodwill	$ 78	$ 0
Accumulated impairment losses	0	0
Total	78	0
Goodwill acquired during the year and purchase price allocation adjustments	5	78
Total	**$ 83**	**$ 78**
As of December 31:		
Goodwill	$ 83	$ 78
Accumulated impairment losses	0	0
Total	**$ 83**	**$ 78**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of December 31, 2013 and 2012:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2013:			
Capitalized software costs	$ 1,260	$ (475)	$ 785
Long-term debt issuance costs	230	(31)	199
Trade Names	81	0	81
Contracts	64	(2)	62
Other	80	(15)	65
Total	**$ 1,715**	**$ (523)**	**$ 1,192**
As of December 31, 2012:			
Capitalized software costs	$ 927	$ (399)	$ 528
Long-term debt issuance costs	106	(25)	81
Other	43	(2)	41
Total	**$ 1,076**	**$ (426)**	**$ 650**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2013 is as follows:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Amortization of intangible assets	$ 1,102	$ 224	$ 206	$ 126	$ 82	$ 77	$ 387

NOTE 12. INVESTMENTS AND OTHER ASSETS

The principal components of investments and other assets in our accompanying Consolidated Balance Sheets are as follows:

	December 31,	
	2013	2012
Marketable debt securities	$ 62	$ 15
Equity investments in unconsolidated health care entities(1)	56	22
Total investments	118	37
Cash surrender value of life insurance policies	25	21
Long-term deposits	35	16
Land held for expansion, long-term receivables and other assets	227	88
Investments and other assets	**$ 405**	**$ 162**

(1) Equity earnings of unconsolidated affiliates are included in net operating revenues in the accompanying Consolidated Statements of Operations and were $15 million and $8 million in of the years ended December 31, 2013 and 2012, respectively.

Our policy is to classify investments that may be needed for cash requirements as "available-for-sale." In doing so, the carrying values of the shares and debt instruments are adjusted at the end of each accounting period to their market values through a credit or charge to other comprehensive income (loss), net of taxes. At both December 31, 2013 and 2012, there were less than $1 million of accumulated unrealized gains on these investments.

NOTE 13. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

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	December 31, 2013	December 31, 2012
Unamortized realized losses from interest rate lock derivatives	$ —	$ (1)
Adjustments for defined benefit plans	(24)	(67)
Accumulated other comprehensive loss	**$ (24)**	**$ (68)**

There was a tax effect allocated to the adjustments for our defined benefit plans for the years ended December 31, 2013 and 2012 of $(25) million and $9 million, respectively.

NOTE 14. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Insurance

At December 31, 2013 and 2012, the aggregate current and long-term professional and general liability reserves in our accompanying Consolidated Balance Sheets were approximately $699 million and $356 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.45%, 1.18% and 1.35% at December 31, 2013, 2012 and 2011, respectively.

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period.

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of $112 million, $92 million and $108 million for the years ended December 31, 2013, 2012 and 2011, respectively.

NOTE 15. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

Governmental Reviews

Health care companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. Certain of our individual facilities have received inquiries from government agencies, and our facilities may receive such inquiries in future periods. The following material governmental reviews, which have been previously reported, are currently pending.

- *Kyphoplasty*—From March 2009 through July 2010, seven of our hospitals became the subject of a review by the U.S. Department of Justice ("DOJ") and certain other federal agencies regarding the appropriateness of inpatient treatment for Medicare patients receiving kyphoplasty, which is a surgical procedure used to treat certain spinal conditions. We believe this review is part of a national investigation and is related to a qui tam settlement between the government and the manufacturer and distributor of Kyphon, the product used in performing kyphoplasty procedures. In January 2013, we paid $900,000 to settle potential Medicare reimbursement claims against one of our hospitals subject to this review. Management has established a reserve, as described below, to reflect the current

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estimate of probable liability for two of the remaining hospitals under review. We are unable to calculate an estimate of loss or a range of loss with respect to the four other hospitals because (i) our external clinical expert has not completed its report on the billing practices of two of those hospitals, and (ii) we have not reached agreement with the DOJ on the appropriate review methodology with respect to the remaining two hospitals. We are engaged in potential settlement discussions with the DOJ to resolve this matter, but it is impossible at this time to predict the outcome of those discussions or the amount of any potential resolution.

- *Implantable Cardioverter Defibrillators ("ICDs")*—At this time, 52 of our hospitals are part of a nationwide investigation to determine if ICD procedures from 2002 to 2010 complied with Medicare coverage requirements. (The number of our hospitals under review may increase or decrease depending on the timeframe of the government's examination, which commenced in March 2010.) In August 2012, the DOJ released its "Medical Review Guidelines/Resolution Model," which sets out, for purposes of this investigation, the patient conditions and criteria for the medical necessity of the implantation of ICDs in Medicare beneficiaries and how the DOJ will enforce the repayment obligations of hospitals. Management has established a reserve, as described below, to reflect the current estimate of probable liability for 21 of the hospitals under review. We are unable to calculate an estimate of loss or a range of loss with respect to the 31 other hospitals because our external clinical expert has not completed its report on the billing practices of those hospitals. We are engaged in potential settlement discussions with the DOJ to resolve this matter, but it is impossible at this time to predict the outcome of those discussions or the amount of any potential resolution.

- *Clinica de la Mama Investigations and Qui Tam Action*—As previously reported, we received a subpoena in May 2012 from the Office of Inspector General ("OIG") of U.S. Department of Health and Human Services in Atlanta seeking documents from January 2004 through May 2012 related to the relationship that certain of our Georgia and South Carolina hospitals had with Hispanic Medical Management, Inc. ("HMM"). HMM is an unaffiliated entity that owns and operates clinics that provide, among other things, prenatal care predominantly to uninsured patients. The hospitals contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. The civil investigation is being conducted by the Civil Division of the DOJ, the U.S. Attorney's Office for the Middle District of Georgia and the Georgia Attorney General's Office, while the parallel criminal investigation is being conducted by the Criminal Division of the DOJ and the U.S. Attorney's Office for the Northern District of Georgia.

  The investigations arose out of a qui tam action captioned *United States of America, ex. rel. Ralph D. Williams v. Health Management Associates, Inc., et al.* filed in the U.S. District Court for the Middle District of Georgia. Tenet and four of its hospital subsidiaries are defendants in the qui tam action, which alleges that the arrangements the hospitals had with HMM violated the federal and state anti-kickback statutes and false claims acts. The Georgia Attorney General's Office, on behalf of the State of Georgia, has intervened in the qui tam action and, on February 18, 2014, the Civil Division of the DOJ and the U.S. Attorney's Office for the Middle District of Georgia filed a motion seeking leave of court to intervene in the action on behalf of the United States. Our motion to dismiss, which was filed on November 8, 2013, is pending.

  If we or our subsidiaries were determined to have violated the anti-kickback statutes, the government could require us to reimburse related government program payments received during the subject period, assess civil monetary penalties including treble damages, exclude individuals or subsidiaries from participation in federal health care programs, or seek criminal sanctions against current or former employees of our hospital subsidiary companies or the hospital companies themselves. Management has established a reserve, as described below, to reflect the current estimate of probable liability for these matters, but it is impossible at this time to predict the amount and terms of any potential resolution. We will continue to vigorously defend against the government's allegations.

Except with respect to the matter settled in January 2013 involving one hospital, as discussed above, our analysis of each of these pending reviews is still ongoing, and we are unable to predict with any certainty the progress or final outcome of any discussions with government agencies at this time. Based on currently available information, as of December 31, 2013, we had recorded reserves of approximately $27 million in the aggregate for our potential reimbursement obligations with respect to 23 hospitals under review for their billing practices for kyphoplasty and cardiac defibrillator implantation procedures, as well as the Clinica de la Mama matters. Changes in the reserves may be required in the future as additional information becomes available. We cannot predict the ultimate resolution of any governmental review, and the final amounts paid in settlement or otherwise, if any, could differ materially from our currently recorded reserves.

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Settlement of Previously Reported Litigation

- *Hospital-Related Tort Claim*—In 2013, we settled for $8 million a previously disclosed lawsuit — which was captioned *Rosenberg v. Encino-Tarzana Regional Medical Center and Tenet Healthcare Corporation* — filed in January 2007 in connection with an alleged April 2006 assault at Tarzana Regional Medical Center (a hospital we divested in 2008).

- *Class Action Lawsuits Relating to Vanguard Acquisition*—In August 2013, Vanguard entered into a proposed settlement agreement with respect to two class action lawsuits filed in June 2013 on behalf of Vanguard stockholders in the Chancery Court for Davidson County, Tennessee, captioned *James A. Kaurich v. Vanguard Health Systems, Inc., et al.*, and *Marion Edinburgh TTEE FBO Marion Edinburgh Trust U/T/D/ 7/8/1991 v. Vanguard Health Systems, Inc., et al.* In January 2014, the court issued a preliminary order approving the proposed settlement. The final hearing to approve the settlement is scheduled to be held in April 2014. Under the terms of the settlement, Vanguard made certain supplemental disclosures related to the acquisition, extended the period for its stockholders to exercise their appraisal rights (which has since expired), and agreed to pay the fees and expenses of the plaintiffs' counsel. The settlement will not have a material adverse effect on our business, financial condition or results of operations.

Ordinary Course Matters

We are also subject to other claims and lawsuits arising in the ordinary course of business, including potential claims related to, among other things, the care and treatment provided at our hospitals and outpatient facilities, the application of various federal and state labor laws, tax audits and other matters. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material effect on our business, financial condition or results of operations.

In addition to the proceedings described above, we are defendants in a class action lawsuit in which the plaintiffs claim that in April 1996 patient identifying records from a psychiatric hospital that we closed in 1995 were temporarily placed in an unsecure location while the hospital was undergoing renovations. The lawsuit, *Doe, et al. v. Jo Ellen Smith Medical Foundation*, was filed in the Civil District Court for the Parish of Orleans in Louisiana in March 1997. The plaintiffs allege tortious invasion of privacy and negligent infliction of emotional distress. The plaintiffs contend that the class consists of over 5,000 persons; however, only eight individuals have been identified to date in the class certification process. The plaintiffs have asserted each member of the class is entitled to common damages under a theory of presumed "common damage" regardless of whether or not any members of the class were actually harmed or even aware of the incident. We believe there is no authority for an award of common damages under Louisiana law. In addition, we believe that there is no basis for the certification of this proceeding as a class action under applicable federal and Louisiana law precedents. The lawsuit is expected to be tried in June 2014. We are not able to estimate the reasonably possible loss or a reasonably possible range of loss given: the small number of class members that have been identified or otherwise responded to the class certification process; the novel theories asserted by plaintiffs, including their assertion that a theory of presumed common damage exists under Louisiana law; and the failure of the plaintiffs to provide any evidence of damages. We intend to vigorously contest the plaintiffs' claims.

New claims or inquiries may be initiated against us from time to time. These matters could (1) require us to pay substantial damages or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under our insurance policies where coverage applies and is available, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) cause us to close or sell hospitals or otherwise modify the way we conduct business.

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The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the years ended December 31, 2013, 2012 and 2011:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Year Ended December 31, 2013					
Continuing operations	$ 5	$ 31	$ (10)	$ 14	$ 40
Discontinued operations	5	2	(1)	0	6
	$ 10	**$ 33**	**$ (11)**	**$ 14**	**$ 46**
Year Ended December 31, 2012					
Continuing operations	$ 49	$ 5	$ (49)	$ 0	$ 5
Discontinued operations	17	0	(12)	0	5
	$ 66	**$ 5**	**$ (61)**	**$ 0**	**$ 10**
Year Ended December 31, 2011					
Continuing operations	$ 30	$ 55	$ (36)	$ 0	$ 49
Discontinued operations	0	17	0	0	17
	$ 30	**$ 72**	**$ (36)**	**$ 0**	**$ 66**

For the years ended December 31, 2013, 2012 and 2011, we recorded net costs of $33 million, $5 million and $72 million, respectively, in connection with significant legal proceedings and investigations. The 2013 and 2012 amounts primarily related to costs associated with various legal proceedings and governmental reviews. The 2011 amount primarily related to costs associated with our evaluation of an unsolicited acquisition proposal received in November 2010 (which was subsequently withdrawn), changes in reserve estimates established in connection with certain governmental reviews described above, accruals for a physician privileges case and certain hospital-related tort claims, the settlement of a union arbitration claim, and costs to defend various matters. The amount for 2013 in the column entitled "Other" above relates to the reserves assumed as part of our acquisition of Vanguard in October 2013.

NOTE 16. INCOME TAXES

The provision for income taxes for continuing operations for the years ended December 31, 2013, 2012 and 2011 consists of the following:

	Years Ended December 31,		
	2013	2012	2011
Current tax expense (benefit):			
Federal	$ 2	$ (3)	$ 0
State	4	11	(6)
	6	8	(6)
Deferred tax expense (benefit):			
Federal	(56)	117	62
State	(15)	0	5
	(71)	117	67
	$ (65)	**$ 125**	**$ 61**

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A reconciliation between the amount of reported income tax expense (benefit) and the amount computed by multiplying income (loss) from continuing operations before income taxes by the statutory federal income tax rate is shown below:

	Years Ended December 31,		
	2013	2012	2011
Tax expense at statutory federal rate of 35%	$ (55)	$ 117	$ 57
State income taxes, net of federal income tax benefit	1	13	10
Tax attributable to noncontrolling interests	(10)	(4)	(4)
Nondeductible transaction costs	6	0	0
Other changes in valuation allowance	(2)	(5)	(2)
Change in tax contingency reserves, including interest	(7)	(1)	(12)
Prior-year provision to return adjustment and other changes in deferred taxes, net of valuation allowance	3	3	7
Other items	(1)	2	5
	$ (65)	**$ 125**	**$ 61**

Deferred income taxes reflect the tax effects of temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amount used for income tax purposes. The following table discloses those significant components of our deferred tax assets and liabilities, including any valuation allowance:

	December 31, 2013		December 31, 2012	
	Assets	Liabilities	Assets	Liabilities
Depreciation and fixed-asset differences	$ 0	$ 678	$ 0	$ 375
Reserves related to discontinued operations and restructuring charges	20	0	5	0
Receivables (doubtful accounts and adjustments)	209	0	173	0
Deferred gain on debt exchanges	0	53	0	53
Accruals for retained insurance risks	288	0	182	0
Intangible assets	0	163	0	122
Other long-term liabilities	76	0	55	0
Benefit plans	299	0	214	0
Other accrued liabilities	60	0	11	0
Investments and other assets	0	45	6	0
Net operating loss carryforwards	708	0	588	0
Stock-based compensation	28	0	32	0
Other items	29	0	36	0
	1,717	**939**	**1,302**	**550**
Valuation allowance	(107)	0	(56)	0
	$ 1,610	**$ 939**	**$ 1,246**	**$ 550**

Below is a reconciliation of the deferred tax assets and liabilities and the corresponding amounts reported in the accompanying Consolidated Balance Sheets.

	December 31,	
	2013	2012
Current portion of deferred income tax asset	$ 581	$ 354
Deferred income tax asset, net of current portion	90	342
Noncurrent deferred income tax liability	0	0
Net deferred tax asset	**$ 671**	**$ 696**

During the year ended December 31, 2013, the valuation allowance increased by $51 million, $34 million due to the acquisition of Vanguard and $17 million primarily due to the adjustment of deferred tax assets for state net operating loss carryforwards that have a full valuation allowance. The $107 million balance in the valuation allowance as of December 31, 2013 is primarily attributable to certain state net operating loss carryovers that, more likely than not, will expire unutilized. During the year ended December 31, 2012, we reduced the valuation allowance by an additional $5 million based on 2012 profits and projected profits for 2013. During the year ended December 31, 2011, we reduced the valuation allowance for our deferred tax assets by $5 million based on 2011 profits and projected profits for 2012.

We account for uncertain tax positions in accordance with ASC 740-10-25, which prescribes a comprehensive model for the financial statement recognition, measurement, presentation and disclosure of uncertain tax positions taken or expected to be

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taken in income tax returns. The table below summarizes the total changes in unrecognized tax benefits during the years ended December 31, 2013, 2012 and 2011. The additions and reductions for tax positions include the impact of items for which the ultimate deductibility is highly certain, but for which there is uncertainty about the timing of such deductions. Such amounts include unrecognized tax benefits that have impacted deferred tax assets and liabilities at December 31, 2013, 2012 and 2011.

	Continuing Operations	Discontinued Operations	Total
Balance at December 31, 2010	**34**	**1**	**35**
Additions for prior-year tax positions	15	0	15
Reductions for tax positions of prior years	(2)	0	(2)
Additions for current-year tax positions	3	0	3
Reductions for current-year tax positions	0	0	0
Reductions due to settlements with taxing authorities	(12)	0	(12)
Reductions due to a lapse of statute of limitations	(4)	0	(4)
Balance at December 31, 2011	**34**	**1**	**35**
Additions for prior-year tax positions	0	0	0
Reductions for tax positions of prior years	(2)	0	(2)
Additions for current-year tax positions	2	0	2
Reductions for current-year tax positions	0	0	0
Reductions due to settlements with taxing authorities	(3)	0	(3)
Reductions due to a lapse of statute of limitations	(0)	0	(0)
Balance at December 31, 2012	**31**	**1**	**32**
Additions for prior-year tax positions	15	0	15
Reductions for tax positions of prior years	(0)	0	(0)
Additions for current-year tax positions	3	0	3
Reductions for current-year tax positions	0	0	0
Reductions due to settlements with taxing authorities	(0)	0	(0)
Reductions due to a lapse of statute of limitations	(6)	(1)	(7)
Balance at December 31, 2013	**$ 43**	**$ 0**	**$ 43**

The total amount of unrecognized tax benefits as of December 31, 2013 was $43 million, of which $34 million, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing operations. Income tax expense in the year ended December 31, 2013 includes a benefit of $1 million in continuing operations attributable to a decrease in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2012 was $32 million, which, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2012 includes expense of $3 million in continuing operations attributable to an increase in our estimated liabilities for uncertain tax positions, net of related deferred tax effects. The total amount of unrecognized tax benefits as of December 31, 2011 was $35 million which, if recognized, would affect our effective tax rate and income tax expense (benefit) from continuing and discontinued operations. Income tax expense in the year ended December 31, 2011 includes a benefit of $21 million ($2 million related to continuing operations and $19 million related to discontinued operations) attributable to a reduction in our estimated liabilities for uncertain tax positions, net of related deferred tax effects, primarily as a result of audit settlements and the expiration of statutes of limitation.

Our practice is to recognize interest and/or penalties related to income tax matters in income tax expense in our consolidated statements of operations. Approximately $1 million of interest and penalties related to accrued liabilities for uncertain tax positions related to continuing operations are included in the accompanying Consolidated Statement of Operations for the year ended December 31, 2013. Total accrued interest and penalties on unrecognized tax benefits as of December 31, 2013 were $5 million, all of which related to continuing operations.

The Internal Revenue Service ("IRS") has completed the audits of our tax returns for all tax years ending on or before December 31, 2007. All disputed issues with respect to these audits have been resolved and all related tax assessments (including interest) have been paid. Tax returns for years ended after December 31, 2007 are not currently under examination by the IRS. During 2011, the resolution of tax and interest computations by the IRS resulted in a net refund of tax and interest of $18 million with respect to the tax years ended May 31, 1998 through December 31, 2003, and payment of $15 million of tax and interest with respect to the tax years ended December 31, 2006 and 2007.

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As of December 31, 2013, approximately $1 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

At December 31, 2013, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax expiring in 2024 to 2033, (2) approximately $19 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $14 million expiring in 2023 through 2031, and (4) state NOL carryforwards of $3.8 billion expiring in 2014 through 2033 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $34 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if certain ownership changes in our company occur during a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs (see Note 2), the offering of stock by us, the purchase or sale of our stock by 5% shareholders, as defined in the Treasury regulations, or the issuance or exercise of rights to acquire our stock. If such ownership changes by 5% shareholders result in aggregate increases that exceed 50 percentage points during the three-year period, then Section 382 imposes an annual limitation on the amount of our taxable income that may be offset by the NOL carryforwards or tax credit carryforwards at the time of ownership change.

NOTE 17. EARNINGS (LOSS) PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for income (loss) from continuing operations for the years ended December 31, 2013, 2012 and 2011. Income (loss) is expressed in millions and weighted average shares are expressed in thousands.

	Income (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Year Ended December 31, 2013			
Loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (123)	101,648	$ (1.21)
Effect of dilutive stock options and restricted stock units	0	0	0.00
Loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (123)**	**101,648**	**$ (1.21)**
Year Ended December 31, 2012			
Income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 185	104,200	$ 1.77
Effect of dilutive stock options and restricted stock units	0	4,726	(0.07)
Income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 185**	**108,926**	**$ 1.70**
Year Ended December 31, 2011			
Income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 68	117,182	$ 0.58
Effect of dilutive stock options and restricted stock units	0	4,113	(0.02)
Income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 68**	**121,295**	**$ 0.56**

All potentially dilutive securities were excluded from the calculation of diluted earnings (loss) per share for the year ended December 31, 2013 because we did not report income from continuing operations in the period. In circumstances where we do not have income from continuing operations, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations in that period, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase of 2,310. Stock options (in thousands) whose exercise price exceeded the average market price of our common stock and, therefore, were not included in the computation of diluted shares for the years ended December 31, 2013, 2012 and 2011 were 755, 2,876 and 3,421 shares, respectively.

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NOTE 18. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of December 31, 2013 and 2012. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

	December 31, 2013	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Marketable securities – current	$ 1	$ 1	$ 0	$ 0
Investments in Reserve Yield Plus Fund	2	0	2	0
Marketable debt securities – noncurrent	62	23	38	1
	$ 65	**$ 24**	**$ 40**	**$ 1**

	December 31, 2012	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Marketable securities – current	$ 4	$ 4	$ 0	$ 0
Investments in Reserve Yield Plus Fund	2	0	2	0
Marketable debt securities – noncurrent	14	2	11	1
	$ 20	**$ 6**	**$ 13**	**$ 1**

There was no change in the fair value of our auction rate securities valued using significant unobservable inputs during the years ended December 31, 2013 or 2012.

At December 31, 2013, one of our captive insurance subsidiaries held $1 million of preferred stock and other securities that were distributed from auction rate securities whose auctions have failed due to sell orders exceeding buy orders. We were not required to record an other-than-temporary impairment of these securities during the years ended December 31, 2013 or 2012.

Our non-financial assets and liabilities not permitted or required to be measured at fair value on a recurring basis typically relate to long-lived assets held and used, long-lived assets held for sale and goodwill. We are required to provide additional disclosures about fair value measurements as part of our financial statements for each major category of assets and liabilities measured at fair value on a non-recurring basis. The following table presents this information and indicates the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities, which generally are not applicable to non-financial assets and liabilities. Fair values determined by Level 2 inputs utilize data points that are observable, such as definitive sales agreements, appraisals or established market values of comparable assets. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability and include situations where there is little, if any, market activity for the asset or liability, such as internal estimates of future cash flows.

	December 31, 2013	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-lived assets held and used	$ 44	$ —	$ 44	$ —

As described in Note 5, we recorded a $12 million impairment charge in continuing operations in the year ended December 31, 2013 for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment.

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The fair value of our long-term debt is based on quoted market prices (Level 1). At December 31, 2013 and 2012, the estimated fair value of our long-term debt was approximately 103.5% and 108.2%, respectively, of the carrying value of the debt.

NOTE 19. ACQUISITIONS

During the year ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $1.515 billion.

We are required to allocate the purchase prices of the acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment primarily for Vanguard and several recent acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed. During the year ended December 31, 2013, we made adjustments to purchase price allocations for businesses acquired in 2012 that increased goodwill by approximately $5 million.

During the year ended December 31, 2012, we acquired a diagnostic imaging center, an oncology center, an urgent care center, a health plan, a cyberknife center in which we previously held a noncontrolling interest, a majority interest in nine ambulatory surgery centers (in one of which we had previously held a noncontrolling interest), as well as 20 physician practice entities and a physician practice management company in which we had previously held a noncontrolling interest as part of our Hospital Operations and other segment. Also during the year ended December 31, 2012, our Conifer segment acquired an information management and services company and a hospital revenue cycle management business. The purchase price was $211 million.

Preliminary purchase price allocations for all the acquisitions made during the years ended December 31, 2013 and 2012 are as follows:

	2013	2012
Current assets	$ 1,058	$ 19
Property and equipment	3,134	24
Other intangible assets	166	53
Goodwill	2,121	182
Investments and other assets	83	0
Other long-term assets	126	0
Current liabilities	(1,024)	(23)
Deferred tax liabilities	(174)	0
Long-term liabilities	(3,741)	(7)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(175)	0
Noncontrolling interests	(49)	(37)
Net cash paid	**$ 1,515**	**$ 211**
Gain on business combination	**$ 10**	**$ 0**

The goodwill generated from these transactions, the majority of which will not be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and increased reimbursement. Approximately $52 million and $6 million in transaction costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2013 and 2012, respectively, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Consolidated Statements of Operations.

Included in equity earnings of unconsolidated affiliates is $10 million of earnings associated with stepping up our basis in a previously held investment in an ambulatory surgery center in which we acquired a controlling interest and are now consolidating for the year ended December 31, 2013.

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Acquisition of Vanguard Health Systems

Effective October 1, 2013, we acquired the common stock of Vanguard for $21 per share in an all cash transaction. Vanguard owned and operated 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas. We paid approximately $4.3 billion to acquire Vanguard, including the assumption of $2.5 billion of Vanguard's net debt. We have not yet finalized the analysis required to complete the purchase price allocation for this acquisition and the related disclosures.

The preliminary purchase price allocation for our Vanguard acquisition is as follows:

Current assets	$	1,054
Investments and other assets		82
Property and equipment		3,074
Other long term assets		118
Other intangible assets		108
Goodwill		1,936
Current liabilities		(1,012)
Deferred taxes long term		(161)
Long-term liabilities		(3,726)
Redeemable noncontrolling interests in equity of consolidated subsidiaries		(165)
Noncontrolling interests		(7)
Net cash paid	$	1,301

Pro Forma Information - Unaudited

The following table provides certain pro forma financial information for Tenet as if the Vanguard Health Systems acquisition had occurred at the beginning of the year ended December 31, 2012.

	Year Ended December 31,	
	2013	2012
Net operating revenues	$ 15,650	$ 15,140
Income (loss) from continuing operations , before income taxes	$ (294)	$ 294

NOTE 20. SEGMENT INFORMATION

In the three months ended June 30, 2012, we began reporting Conifer as a separate reportable business segment. Our other segment is Hospital Operations and other. Historically, our business has consisted of one reportable segment. However, during the three months ended June 30, 2012, our Hospital Operations and other segment and our Conifer subsidiary entered into formal agreements, pursuant to which it was agreed that services provided by both parties to each other would be billed based on estimated third-party pricing terms. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Our core business is Hospital Operations and other, which is focused on owning and operating acute care hospitals and outpatient facilities. We also own various related health care businesses. At December 31, 2013, our subsidiaries operated 77 hospitals with a total of 20,293 licensed beds, primarily serving urban and suburban communities, as well as 183 outpatient centers, six health plans and six accountable care networks.

We operate revenue cycle management and patient communications and engagement services businesses under our Conifer subsidiary. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. At December 31, 2013, Conifer provided services to more than 700 Tenet and non-Tenet hospital and other clients nationwide.

As mentioned above, in 2012, our Conifer subsidiary and our Hospital Operations and other segment entered into formal agreements documenting terms and conditions of various services provided by Conifer to Tenet hospitals, as well as certain administrative services provided by our Hospital Operations and other segment to Conifer. The services provided by both parties under these agreements are charged to the other party based on estimated third-party pricing terms. In 2011, the services provided by both parties were charged to the other party based on an estimate of the internal costs to provide such

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services. The amounts in the tables directly below reflect the services being charged based on estimated third-party terms in 2013 and 2012, but not in 2011.

The following table includes amounts for each of our reportable segments and the reconciling items necessary to agree to amounts reported in the accompanying Consolidated Balance Sheets and Consolidated Statements of Operations:

	December 31,		
	2013	2012	2011
Assets:			
Hospital Operations and other	$ 15,874	$ 8,825	$ 8,389
Conifer	256	219	73
Total	**$ 16,130**	**$ 9,044**	**$ 8,462**

	Year Ended December 31,		
	2013	2012	2011
Capital expenditures:			
Hospital Operations and other Core Services	$ 670	$ 495	$ 461
Conifer	21	13	14
Total	**$ 691**	**$ 508**	**$ 475**
Net operating revenues:			
Hospital Operations and other	$ 10,587	$ 9,002	$ 8,575
Conifer			
Tenet	404	371	261
Other customers	515	117	79
	11,506	9,490	8,915
Intercompany eliminations	(404)	(371)	(261)
Total	**$ 11,102**	**$ 9,119**	**$ 8,654**
Adjusted EBITDA:			
Hospital Operations and other Core Services	$ 1,210	$ 1,098	$ 1,083
Conifer	132	105	43
Total	**$ 1,342**	**$ 1,203**	**$ 1,126**
Depreciation and amortization:			
Hospital Operations and other Core Services	$ 526	$ 420	$ 389
Conifer	19	10	9
Total	**$ 545**	**$ 430**	**$ 398**
Adjusted EBITDA	**$ 1,342**	**$ 1,203**	**$ 1,126**
Depreciation and amortization	(545)	(430)	(398)
Impairment and restructuring charges, and acquisition-related costs	(103)	(19)	(20)
Litigation and investigation costs	(31)	(5)	(55)
Interest expense	(474)	(412)	(375)
Loss from early extinguishment of debt	(348)	(4)	(117)
Investment earnings	1	1	3
Income (loss) before income taxes	**$ (158)**	**$ 334**	**$ 164**

NOTE 21. RECENT ACCOUNTING STANDARDS

Changes in Accounting Principle

Effective January 1, 2011, we adopted ASU 2010-24, "Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries," which clarifies that a health care entity should not net insurance recoveries against a related claim liability. The adoption had no impact on our financial condition, results of operations or cash flows.

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Effective January 1, 2011, we adopted ASU 2010-23, "Health Care Entities (Topic 954): Measuring Charity Care for Disclosure," which prescribes a specific measurement basis of charity care for disclosure. The adoption had no impact on our financial condition, results of operations or cash flows.

Effective December 31, 2011, we adopted ASU 2011-07, "Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities," which requires health care entities to present the provision for doubtful accounts relating to patient service revenue as a deduction from patient service revenue in the statement of operations rather than as an operating expense. Additional disclosures relating to sources of patient revenue and the allowance for doubtful accounts related to patient accounts receivable are also required. Such additional disclosures are included in Notes 1 and 3. The adoption of this ASU had no impact on our financial condition, results of operations or cash flows.

Effective December 31, 2012, we adopted ASU 2012-02, "Intangibles—Goodwill and Other (Topic 350): Testing Indefinite-Lived Intangible Assets for Impairment," which permits an entity to first assess qualitative factors to determine whether it is more likely than not that an indefinite-lived intangible asset is impaired as a basis for determining whether it is necessary to perform the quantitative impairment test as described in Topic 350. The adoption of this standard had no impact on our financial condition, results of operations or cash flows

Recently Issued Accounting Standards

In July 2013, the FASB issued, ASU No. 2013-11 "Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists" ("ASU 2013-11"). ASU 2013-11 addresses the diversity in practice that exists for the balance sheet presentation of an unrecognized tax benefit when a net operating loss carryforward, a similar tax loss, or a tax credit carryforward exists. ASU 2013-11 requires that an unrecognized tax benefit, or a portion of an unrecognized tax benefit, should be presented in the financial statements as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward. ASU No. 2013-11 is effective for our fiscal quarter ending March 31, 2014. ASU 2013-11 impacts balance sheet presentation only. We do not expect the adoption of this standard to impact our balance sheet.

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SUPPLEMENTAL FINANCIAL INFORMATION

SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)

	Year Ended December 31, 2013			
	First	Second	Third	Fourth
Net operating revenues	$ 2,387	$ 2,422	$ 2,408	$ 3,885
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ (88)	$ (50)	$ 28	$ (24)
Net income (loss)	$ (83)	$ (43)	$ 36	$ (14)
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic	$ (0.85)	$ (0.49)	$ 0.28	$ (0.24)
Diluted	$ (0.85)	$ (0.49)	$ 0.27	$ (0.24)

	Year Ended December 31, 2012			
	First	Second	Third	Fourth
Net operating revenues	$ 2,302	$ 2,265	$ 2,221	$ 2,331
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ 58	$ (6)	$ 40	$ 49
Net income (loss)	$ 67	$ (20)	$ 32	$ 54
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic	$ 0.56	$ (0.06)	$ 0.38	$ 0.46
Diluted	$ 0.53	$ (0.06)	$ 0.37	$ 0.45

Quarterly operating results are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid funding levels set by the states in which we operate; the timing of approval by CMS of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related health care facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local health care competitors; managed care contract negotiations or terminations; any unfavorable publicity about us, which impacts our relationships with physicians and patients; changes in health care regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

All amounts related to shares, share prices and earnings per share have been restated to give retrospective presentation for the reverse stock split described in Note 2.

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ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

We completed our acquisition of Vanguard effective October 1, 2013. The facilities acquired as part of the Vanguard acquisition utilize different information technology systems than our other facilities. We have excluded all of the Vanguard operations from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. The rules of the Securities and Exchange Commission ("SEC") require us to include acquired entities in our assessment of the effectiveness of internal control over financial reporting no later than the annual management report following the first anniversary of the acquisition. We will complete the evaluation and integration of the Vanguard operations within the required timeframe and report management's assessment of our internal control over financial reporting, including the acquired hospitals and other operations, in our first annual report in which such assessment is required. Other than the Vanguard acquisition, there were no changes in our internal control over financial reporting during the quarter ended December 31, 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report with respect to our operations that existed prior to the Vanguard acquisition. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Exchange Act and the SEC rules thereunder.

Management's report on internal control over financial reporting is set forth on page 88 and is incorporated herein by reference. The independent registered public accounting firm that audited the financial statements included in this report has issued an attestation report on our internal control over financial reporting as set forth on page 89 herein.

ITEM 9B. OTHER INFORMATION

None.

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PART III.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Certain information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K. Information concerning our *Standards to Conduct*, by which all of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide appears under Item I, Business — Compliance and Ethics, of Part I of this report.

ITEM 11. EXECUTIVE COMPENSATION

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

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PART IV.

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The Consolidated Financial Statements and notes thereto can be found on pages 91 through 129.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 140).

All other schedules and financial statements of the Registrant are omitted because they are not applicable or not required or because the required information is included in the Consolidated Financial Statements or notes thereto.

EXHIBITS

(2) Plan of Acquisition, Reorganization, Arrangement, Liquidation or Succession

(a) Agreement and Plan of Merger, dated as of June 24, 2013, by and among the Registrant, Orange Merger Sub, Inc. and Vanguard Health Systems, Inc. (Incorporated by reference to Exhibit 2.1 to Registrant's Current Report on Form 8-K, dated and filed June 24, 2013)

(3) Articles of Incorporation and Bylaws

(a) Amended and Restated Articles of Incorporation of the Registrant, as amended and restated May 8, 2008 (Incorporated by reference to Exhibit 3(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, filed August 5, 2008)

(b) Certificate of Designation, Preferences, and Rights of Series A Junior Participating Preferred Stock, par value $0.15 per share, dated January 7, 2011 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(c) Certificate of Change Pursuant to NRS 78.209, filed with the Nevada Secretary of State effective October 10, 2012 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K, dated October 10, 2012 and filed October 11, 2012)

(d) Amended and Restated Bylaws of the Registrant, as amended and restated effective January 7, 2011 (Incorporated by reference to Exhibit 3.2 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(b) Third Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee, relating to 6 7/8% Senior Notes due 2031 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(c) Seventh Supplemental Indenture, dated as of June 18, 2004, between the Registrant and The Bank of New York, as trustee, relating to 9 7/8% Senior Notes due 2014 (Incorporated by reference to Exhibit 4(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2004, filed August 3, 2004)

(d) Eighth Supplemental Indenture, dated as of January 28, 2005, between the Registrant and The Bank of New York, as trustee, relating to 9¼% Senior Notes due 2015 (Incorporated by reference to Exhibit 4(g) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2004, filed March 8, 2005)

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(e) Twelfth Supplemental Indenture, dated as of August 17, 2010, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 8% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed August 17, 2010)

(f) Fourteenth Supplemental Indenture, dated as of November 21, 2011, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 6¼% Senior Secured Notes due 2018 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated November 21, 2011 and filed November 22, 2011)

(g) Fifteenth Supplemental Indenture, dated as of October 16, 2012, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 4¾% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(h) Sixteenth Supplemental Indenture, dated as of October 16, 2012, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 6¾% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(i) Seventeenth Supplemental Indenture, dated as of February 5, 2013, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating 4½% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed February 5, 2013)

(j) Twentieth Supplemental Indenture, dated as of May 30, 2013, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating 4 3/8% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated May 30, 2013 and filed May 31, 2013)

(k) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(l) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(m) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8 1/8% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(n) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8 1/8% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(10) Material Contracts

(a) Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated October 19, 2010 and filed October 20, 2010)

(b) Amendment No. 1, dated as of November 29, 2011, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc.,

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as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated November 29, 2011 and filed December 1, 2011)

(c) Amendment No. 2, dated as of January 23, 2014, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein†

(d) Stock Pledge Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated March 3, 2009 and filed March 5, 2009)

(e) Second Amendment to Stock Pledge Agreement, dated as of June 15, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated June 15, 2009 and filed June 16, 2009)

(f) Collateral Trust Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K, dated March 3, 2009 and filed March 5, 2009)

(g) Exchange and Registration Rights Agreement, dated as of October 1, 2013, by and among the Registrant, certain of its subsidiaries, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Barclays Capital Inc., Citigroup Global Markets Inc. and Wells Fargo Securities, LLC (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(h) Letter from the Registrant to Trevor Fetter, dated November 7, 2002 (Incorporated by reference to Exhibit 10(k) to Registrant's Transition Report on Form 10-K for the seven-month transition period ended December 31, 2002, filed May 15, 2003)*

(i) Letter from the Registrant to Trevor Fetter dated September 15, 2003 (Incorporated by reference to Exhibit 10(l) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, filed November 10, 2003)*

(j) Letter from the Registrant to Keith B. Pitts dated June 21, 2013 *†

(k) Letter from the Registrant to Britt T. Reynolds, dated December 15, 2011 (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2011, filed February 28, 2012)*

(l) Letter from the Registrant to Daniel J. Cancelmi, dated September 6, 2012 (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012) *

(m) Letter from the Registrant to Audrey Andrews, accepted January 24, 2013 (Incorporated by reference to Exhibit 10(m) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2012, filed February 26, 2013)*

(n) Letter from the Registrant to Cathy Fraser, dated August 29, 2006 (Incorporated by reference to Exhibit 10(k) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2007, filed February 26, 2008)*

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(o) Letter from the Registrant to R. Scott Ramsey, dated September 10, 2012 (Incorporated by reference to Exhibit 10(d) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(p) Tenet Second Amended and Restated Executive Severance Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(e) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(q) Board of Directors Retirement Plan, effective January 1, 1985, as amended August 18, 1993, April 25, 1994 and July 30, 1997 (Incorporated by reference to Exhibit 10(q) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, filed November 10, 2003)*

(r) Tenet Healthcare Corporation Seventh Amended and Restated Supplemental Executive Retirement Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(f) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(s) Ninth Amended and Restated Tenet 2001 Deferred Compensation Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(g) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(t) Second Amended and Restated Tenet 2006 Deferred Compensation Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(h) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(u) Tenet Healthcare Corporation Second Amended and Restated 1994 Directors Stock Option Plan (Incorporated by reference to Exhibit 10(u) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(v) First Amended and Restated 1991 Stock Incentive Plan (Incorporated by reference to Exhibit 10(v) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(w) Second Amended and Restated 1995 Stock Incentive Plan (Incorporated by reference to Exhibit 10(w) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(x) Second Amended and Restated Tenet Healthcare Corporation 1999 Broad-Based Stock Incentive Plan (Incorporated by reference to Exhibit 10(x) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(y) Fifth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(i) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(z) Form of Stock Award used to evidence grants of stock options and/or restricted units under the Fourth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan (Incorporated by reference to Exhibit 10.3 to Registrant's Current Report on Form 8-K, dated February 14, 2006 and filed February 17, 2006)*

(aa) Third Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(j) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(bb) Forms of Award used to evidence (i) initial grants of restricted stock units to directors, (ii) annual grants of restricted stock units to directors, (iii) grants of stock options to executives, and (iv) grants of restricted stock units to executives, all under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(aa) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2008, filed February 24, 2009)*

(cc) Award Agreement, dated June 13, 2013, used to evidence grant of performance-based restricted stock units to Trevor Fetter under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by

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reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, filed August 6, 2013)*

(dd) Form of Award used to evidence grants of performance cash awards under the Fourth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan and the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Registrant's Annual Report on Form 10-K for the year ended December 31, 2009, filed February 23, 2010)*

(ee) Tenet Special RSU Deferral Plan (Incorporated by reference to Exhibit 10(d) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009, filed May 5, 2009)*

(ff) Second Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(k) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(gg) Form of Indemnification Agreement entered into with each of the Registrant's directors (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, filed November 1, 2005)

(21) Subsidiaries of the Registrant†

(23) Consent of Deloitte & Touche LLP†

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Trevor Fetter, President and Chief Executive Officer†

(b) Certification of Daniel J. Cancelmi, Chief Financial Officer†

(32) Section 1350 Certifications of Trevor Fetter, President and Chief Executive Officer, and Daniel J. Cancelmi, Chief Financial Officer†

(101 INS) XBRL Instance Document

(101 SCH) XBRL Taxonomy Extension Schema Document

(101 CAL) XBRL Taxonomy Extension Calculation Linkbase Document

(101 DEF) XBRL Taxonomy Extension Definition Linkbase Document

(101 LAB) XBRL Taxonomy Extension Label Linkbase Document

(101 PRE) XBRL Taxonomy Extension Presentation Linkbase Document

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* Management contract or compensatory plan or arrangement.
† Filed herewith.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: February 24, 2014 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Date: February 24, 2014 By: /s/ TREVOR FETTER
Trevor Fetter
President, Chief Executive Officer and Director
(Principal Executive Officer)

Date: February 24, 2014 By: /s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer
(Principal Financial Officer)

Date: February 24, 2014 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Date: February 24, 2014 By: /s/ JOHN ELLIS BUSH
John Ellis Bush
Director

Date: February 24, 2014 By: /s/ BRENDA J. GAINES
Brenda J. Gaines
Director

Date: February 24, 2014 By: /s/ KAREN M. GARRISON
Karen M. Garrison
Director

Date: February 24, 2014 By: /s/ EDWARD A. KANGAS
Edward A. Kangas
Director

Date: February 24, 2014 By: /s/ J. ROBERT KERREY
J. Robert Kerrey
Director

Date: February 24, 2014 By: /s/ RICHARD R. PETTINGILL
Richard R. Pettingill
Director

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Date: February 24, 2014 By: /s/ RONALD A. RITTENMEYER
Ronald A. Rittenmeyer
Director

Date: February 24, 2014 By: /s/ JAMES A. UNRUH
James A. Unruh
Director

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SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Additions Charged To: Costs and Expenses(1)(2)	Additions Charged To: Other Accounts	Deductions(3)	Other Items(4)	Balance at End of Period
Allowance for doubtful accounts:						
Year ended December 31, 2013	$ 401	$ 975	$ —	$ (787)	$ —	$ 589
Year ended December 31, 2012	$ 397	$ 789	$ —	$ (785)	$ —	$ 401
Year ended December 31, 2011	$ 352	$ 721	$ —	$ (676)	$ —	$ 397
Valuation allowance for deferred tax assets						
Year ended December 31, 2013	$ 56	$ 23	$ (1)	$ —	$ 29	$ 107
Year ended December 31, 2012	$ 61	$ (5)	$ —	$ —	$ —	$ 56
Year ended December 31, 2011	$ 66	$ (5)	$ —	$ —	$ —	$ 61

(1) Includes amounts recorded in discontinued operations.
(2) Before considering recoveries on accounts or notes previously written off.
(3) Accounts written off.
(4) Vanguard acquisition.

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Exhibit 10(c)

AMENDMENT NO. 2

AMENDMENT NO. 2, dated as of January 23, 2014 (this "*Amendment*"), by and among Tenet Healthcare Corporation, a Nevada corporation (the "*Borrower*"), Citicorp USA, Inc., as Administrative Agent (in such capacity, the "*Administrative Agent*") under the Credit Agreement (as defined below), the Loan Parties and the Lenders party hereto.

PRELIMINARY STATEMENTS:

WHEREAS, reference is hereby made to the Amended and Restated Credit Agreement, dated as of October 19, 2010 (as amended, supplemented, amended and restated or otherwise modified from time to time, the "*Credit Agreement*"), among the Borrower, the Administrative Agent and each Lender and Issuer from time to time party thereto (capitalized terms used but not defined herein having the meaning provided in the Credit Agreement);

WHEREAS, pursuant to Section 11.1 of the Credit Agreement, the Borrower has requested that the Administrative Agent and the Requisite Lenders consent to the amendment to the Credit Agreement set forth herein;

WHEREAS, each Lender party hereto has agreed to consent to the amendment set forth herein, in each case, on the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the premises and agreements, provisions and covenants herein contained, the parties hereto agree as follows:

1. **Amendment to the Credit Agreement**. Effective as of the Amendment Effective Date (as defined below) and subject to the satisfaction of the terms and conditions set forth herein, the definition of "Excluded Subsidiary" is hereby amended and restated in its entirety to read as follows:

   "*Excluded Subsidiary*" means, (a) each Subsidiary of the Borrower designated from time to time by the Borrower as such, unless the Borrower shall have subsequently revoked such designation by written notice of such revocation to the Administrative Agent and such Subsidiary shall have complied with the requirements of *Section 7.10(a) (Additional Collateral and Guaranties)*; *provided*, *however*, that (i) the aggregate total assets of all Excluded Subsidiaries on the last day of the most recent fiscal period for which financial statements have been delivered pursuant to *Section 6.1 (Financial Statements)* shall be less than 30% of the Consolidated total assets of the Borrower and its Subsidiaries as of such date and (ii) the aggregate gross revenues of all such Subsidiaries for any Fiscal Quarter shall be less than 30% of the Consolidated gross revenues of the Borrower and its Subsidiaries for such Fiscal Quarter, in each case determined in accordance with GAAP, (b) any Subsidiary of the Borrower of which less than 60% of the outstanding Voting Stock is, at the time, directly or indirectly, owned or controlled by the Borrower or one or more Guarantors and (c) as of the Effective Date, each of the Subsidiaries of the Borrower listed on *Schedule 1.1(a)* ("*Excluded Subsidiaries*").

2. **Conditions to Effectiveness**. This Amendment shall become effective on the date when each of the following conditions precedent have first been satisfied (the "*Amendment Effective Date*"):

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(a) this Amendment shall have been executed and delivered by the Borrower, the Loan Parties, the Requisite Lenders and the Administrative Agent;

(b) there shall have been paid to the Administrative Agent, for the account of itself and the Lenders, as applicable, all fees and expenses (including, to the extent invoiced, the reasonable fees and expenses of Weil, Gotshal & Manges LLP) due and payable on or before the Amendment Effective Date;

(c) each of the representations set forth in Section 3 hereof shall be true and correct as of the Amendment Effective Date; and

(d) no Default or Event of Default shall have occurred and be continuing as of the Amendment Effective Date.

3. **Representations and Warranties**. By its execution of this Amendment, the Borrower hereby certifies that:

(a) (i) each Loan Party has taken all necessary action to authorize the execution, delivery and performance of this Amendment, (ii) this Amendment has been duly executed and delivered by each Loan Party, (iii) this Amendment is the legal, valid and binding obligation of the each Loan Party, enforceable against it in accordance with its terms, except as enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by general equitable principles and (iv) such execution, delivery and performance will not (A) contravene or violate any Loan Party's Constituent Documents, (B) violate any other Requirement of Law applicable to any Loan Party or any order or decree of any Governmental Authority or arbitrator applicable to the Borrower or (C) conflict with or result in the breach of, or constitute a default under, or result in or permit the termination or acceleration of, any Related Document or any other material Contractual Obligation of any Loan Party;

(b) each of the representations and warranties made by any Loan Party in the Credit Agreement, as amended hereby, and the other Loan Documents to which it respectively is a party or by which it is bound, is true and correct in all material respects on and as of the Amendment Effective Date (other than representations and warranties in any such Loan Document which expressly speak as of a specific date, which shall have been true and correct in all material respects as of such specific date); and

(c) no Default or Event of Default has occurred and is continuing.

4. **Acknowledgments; Liens Unimpaired**. Each Loan Party hereby acknowledges that it has read this Amendment and consents to the terms hereof, and further hereby affirms, confirms, represents, warrants and agrees that (a) notwithstanding the effectiveness of this Amendment, the obligations of such Loan Party under each of the Loan Documents to which it is a party shall not be impaired and each of the Loan Documents to which such Loan Party is a party is, and shall continue to be, in full force and effect and is hereby confirmed and ratified in all respects; (b) after giving effect to this Amendment, (i) the execution, delivery, performance or effectiveness of this Amendment shall not impair the validity, effectiveness or priority of the Liens granted pursuant to the Loan Documents and such Liens shall continue unimpaired with the same priority to secure repayment of all Obligations, whether heretofore or hereafter incurred and (ii) in the case of any Guarantor, its Guaranty, as and to the extent provided in the Loan Documents, shall

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continue in full force and effect in respect of the Obligations under the Credit Agreement and the other Loan Documents; (c) the execution, delivery, performance or effectiveness of this Amendment does not require that any new filings be made or other action taken to perfect or maintain the perfection of such Liens; and (d) the position of the Lenders with respect to such Liens, the Collateral (as defined in the applicable Loan Documents) in which a security interest was granted pursuant to the Loan Documents, and the ability of the Collateral Agent to realize upon such Liens pursuant to the terms of the Loan Documents have not been adversely affected in any material respect by the execution, delivery, performance or effectiveness of this Amendment.

5. **Amendment, Modification and Waiver**. This Amendment may not be amended, modified or waived except in accordance with Section 11.1 of the Credit Agreement.

6. **Entire Agreement**. This Amendment, the Credit Agreement and the other Loan Documents constitute the entire agreement among the parties hereto with respect to the subject matter hereof and thereof and supersede all other prior agreements and understandings, both written and verbal, among the parties hereto with respect to the subject matter hereof. Except as expressly set forth herein, this Amendment shall not by implication or otherwise limit, impair, constitute a waiver of, or otherwise affect the rights and remedies of any party under, the Credit Agreement or other Loan Documents, nor alter, modify, amend or in any way affect any of the terms, conditions, obligations, covenants or agreements contained in the Credit Agreement or other Loan Documents, all of which are ratified and affirmed in all respects and shall continue in full force and effect. It is understood and agreed that each reference in each Loan Document to the Credit Agreement, whether direct or indirect, shall hereafter be deemed to be a reference to the Credit Agreement as amended hereby and that this Amendment is a Loan Document.

7. **GOVERNING LAW AND SUBMISSION TO JURISDICTION. SECTIONS 11.11 AND 11.12 OF THE CREDIT AGREEMENT ARE HEREBY INCORPORATED BY REFERENCE INTO THIS AMENDMENT AND SHALL APPLY HERETO MUTATIS MUTANDIS.**

8. **Waiver of Jury Trial**. Section 11.13 of the Credit Agreement is hereby incorporated by reference into this Amendment and shall apply hereto *mutatis mutandis*.

9. **Counterparts**. Section 11.16 of the Credit Agreement is hereby incorporated by reference into this Amendment and shall apply hereto *mutatis mutandis*.

10. **Entire Agreement**. Section 11.17 of the Credit Agreement is hereby incorporated by reference into this Amendment and shall apply hereto *mutatis mutandis*.

[SIGNATURE PAGES FOLLOW]

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IN WITNESS WHEREOF, each of the undersigned has caused its duly authorized officer to execute and deliver this Amendment as of the date first written above.

CITICORP USA, INC.
as the Administrative Agent

By: /s/ Justin McMahan
Name: Justin McMahan
Title: Vice President

TENET HEALTHCARE CORPORATION,
as the Borrower

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

AMISUB (SFH), INC.
AMISUB OF NORTH CAROLINA, INC.
AMISUB OF SOUTH CAROLINA, INC.
BROOKWOOD HEALTH SERVICES, INC.
COASTAL CAROLINA MEDICAL CENTER, INC.
DELRAY MEDICAL CENTER, INC.
DOCTORS HOSPITAL OF MANTECA, INC.
DOCTORS MEDICAL CENTER OF MODESTO, INC.
EAST COOPER COMMUNITY HOSPITAL, INC.
FOUNTAIN VALLEY REGIONAL HOSPITAL AND MEDICAL CENTER
FRYE REGIONAL MEDICAL CENTER, INC.
HOUSTON SPECIALTY HOSPITAL, INC.
JFK MEMORIAL HOSPITAL, INC.
LAKEWOOD REGIONAL MEDICAL CENTER, INC.
LIFEMARK HOSPITALS OF FLORIDA, INC.
LOS ALAMITOS MEDICAL CENTER, INC.
NORTH FULTON MEDICAL CENTER, INC.
PALM BEACH GARDENS COMMUNITY HOSPITAL, INC.
PLACENTIA-LINDA HOSPITAL, INC.
SIERRA VISTA HOSPITAL, INC.
TENET GOOD SAMARITAN, INC.
TENET HEALTHSYSTEM BARTLETT, INC.
TENET HEALTHSYSTEM DESERT, INC.
TENET HEALTHSYSTEM DI, INC.
TENET HEALTHSYSTEM GB, INC.
TENET HEALTHSYSTEM HOSPITALS, INC.
TENET HEALTHSYSTEM NORTH SHORE, INC.
TENET HEALTHSYSTEM SGH, INC.
TENET HEALTHSYSTEM SL, INC.

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TENET HEALTHSYSTEM SPALDING, INC.
TENET HIALEAH HEALTHSYSTEM, INC.
TENET ST. MARY'S, INC.
TWIN CITIES COMMUNITY HOSPITAL, INC.
WEST BOCA MEDICAL CENTER, INC.

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

CGH HOSPITAL, LTD.
By: Coral Gables Hospital, Inc., as General Partner
HILTON HEAD HEALTH SYSTEM, L.P.
By: Tenet Physician Services — Hilton Head, Inc., as General Partner
NEW MEDICAL HORIZONS II, LTD.
By: Cypress Fairbanks Medical Center Inc., as General Partner
TENET FRISCO, LTD.
By: Tenet Healthsystem Hospitals, Inc., as General Partner
TENET HEALTHSYSTEM HAHNEMANN, L.L.C.
By: Tenet HealthSystem Philadelphia, Inc., as Sole Member
TENET HEALTHSYSTEM ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN, L.L.C.
By: Tenet HealthSystem Philadelphia, Inc., as Sole Member
TENET HOSPITALS LIMITED
By: Tenet Texas, Inc., as General Partner
TH HEALTHCARE, LTD.
By: Lifemark Hospitals, Inc., as General Partner

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

VHS SAN ANTONIO PARTNERS, LLC

By: VHS Acquisition Subsidiary Number 5, Inc., its Managing Member, and VHS Holding Company, Inc.

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

HOSPITAL DEVELOPMENT OF WEST PHOENIX, INC.
VHS ACQUISITION CORPORATION
VHS ACQUISITION SUBSIDIARY NUMBER 1, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 7, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 9, INC.

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VHS CHILDREN'S HOSPITAL OF MICHIGAN, INC.
VHS DETROIT RECEIVING HOSPITAL, INC.
VHS HARPER-HUTZEL HOSPITAL, INC.
VHS HURON VALLEY-SINAI HOSPITAL, INC.
VHS OF ARROWHEAD, INC.
VHS OF ILLINOIS, INC.
VHS REHABILITATION INSTITUTE OF MICHIGAN, INC.
VHS SINAI-GRACE HOSPITAL, INC.
VHS WEST SUBURBAN MEDICAL CENTER, INC.
VHS WESTLAKE HOSPITAL, INC.
VHS OF PHOENIX, INC.

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

CITIBANK, N.A.,
as a Lender

By: /s/ Justin McMahan
Name: Justin McMahan
Title: Vice President

WELLS FARGO CAPITAL FINANCE LLC,
as a Lender

By: /s/ David Klages
Name: David Klages
Title: Duly Authorized Signor

Siemens Financial Services, Inc.,
as a Lender

By: /s/ John Finore
Name: John Finore
Title: Vice President

By: /s/ Uri Sky
Name: Uri Sky
Title: Vice President

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CIT HEALTHCARE LLC,
as a Lender

By: /s/ Barbara Perich
Name: Barbara Perich
Title: Director

Goldman Sachs Bank USA,
as a Lender

By: /s/ Michelle Latzoni
Name: Michelle Latzoni
Title: Authorized Signatory

ROYAL BANK OF CANADA,
as a Lender

By: /s/ Mustafa Topiwalla
Name: Mustafa Topiwalla
Title: Authorized Signatory

Bank of America, N.A.
as a Lender

By: /s/ Laura Weiland
Name: Laura Weiland
Title: Vice President

COMPASS BANK,
as a Lender

By: /s/ Marla Cannon
Name: Marla Cannon
Title: Vice President

[SIGNATURE PAGE TO AMENDMENT]

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Exhibit 10(j)

[TENET LETTERHEAD]

June 21, 2013

Mr. Keith B. Pitts
Vice Chairman
Vanguard Health Systems, Inc.

Dear Keith:

I am pleased to offer you supplemental compensation and benefits in consideration of your transition to Tenet Healthcare Corporation in connection with Tenet's acquisition of Vanguard Health Systems, Inc. ("Acquisition"). By accepting these terms, you agree to waive any occurrence of "good reason" under your employment agreement with Vanguard that results from Vanguard no longer being a publicly-traded company as a result of the Acquisition or your acceptance of your role described herein. Except as modified below, other terms of your employment agreement will remain in effect. The terms included in this letter are contingent on the successful closing of the Acquisition and become effective at that time.

1. Role: Vice Chairman of Tenet, reporting to Tenet's President and Chief Executive Officer. Your position will be located at Tenet's headquarters in Dallas after a reasonable transition period from Nashville to be mutually agreed upon. (See Addendum for additional detail.)

2. Compensation and Benefits: You will be entitled to compensation and benefits as follows:

   a. Base Compensation: Your base compensation will continue to be an annual exempt rate of $700,000.00, payable bi-weekly.

   b. Benefits: You are eligible to receive all standard employee benefits in accordance with Tenet plans.

   c. Annual Incentive Plan: Your position is eligible to participate in Tenet's Annual Incentive Plan (AIP) according to the terms of the Plan. Your target award will continue to be 100% of your base salary. Participating in the AIP does not guarantee that an award will be made.

   d. Manager's Paid Time Off Plan: You are eligible to participate in the company's paid time off plan (the "MTO Plan") according to your tenure with the company (4 weeks per year).

   e. Long Term Incentives. As Vice Chairman, you will be eligible for future long-term incentive grants, which are typically awarded annually and based on guidelines established by Tenet's Compensation Committee. In your role, the current guideline for such an award has an annual value of between $2,000,000 and $2,500,000. In addition, you will receive an up-front grant of restricted stock units ("RSUs") valued at $2,500,000, which will be granted upon closing of the Acquisition. The RSUs will vest in the same manner as standard annual Tenet RSU grants, over three years in one-third annual increments.

3. Relocation: Tenet will provide relocation benefits related to your move to Dallas in accordance with its relocation policies for key executives. The details of these benefits will be provided in a separate communication.

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4. Supplemental Executive Retirement Plan: You will be eligible to participate in Tenet's supplemental executive retirement plan (SERP), which provides enhanced retirement, disability and life insurance benefits, effective as of the close of the Acquisition. Upon completion of five years of service with Tenet following the closing of the Acquisition, the SERP will credit your pre-closing service with Vanguard for purposes of calculating SERP benefits. Details of that plan (e.g., benefit accrual levels, vesting terms) will be provided in a separate communication. Should Tenet's Compensation Committee determine to freeze or terminate the SERP plan following the Acquisition, you will be provided with a substitute of similar value.

5. Executive Severance Plan: At the time specified in the next paragraph, you will be eligible to participate in the Executive Severance Plan, which provides you with certain severance benefits in the event of a Qualifying Termination (i.e., Not for Cause or Good Reason) as defined in the plan. These benefits include severance benefits of two and one-half years of base salary and target annual bonus for a Qualifying Termination, and three years base salary and target annual bonus for Qualifying Termination related to a Change of Control.

   Participation will require execution of a Tenet Executive Severance Plan Agreement. Upon execution of this agreement, which must be completed within one year of the closing of the Acquisition, both parties agree to terminate your existing employment agreement with Vanguard.

   You will receive a separate communication containing more details about the plan, your participation in the plan and an agreement which you will need to sign, from the Executive Compensation Department following your employment date with Tenet.

6. Use of Company Aircraft: You will have priority access to private aircraft for business travel in accordance with Tenet's policies.

All payments to you are subject to applicable tax withholding, and nothing in this letter constitutes a contract to employ you for any specified time. This letter may be modified only by a writing signed by both you and a designated senior officer of Tenet.

If you accept these supplemental items and benefits, please sign and date this letter and return it to me. We are very excited about the Acquisition and look forward to you joining our team.

Sincerely,

/s/ Trevor Fetter

Trevor Fetter
President and CEO

cc: Cathy Fraser, SVP Human Resources
Paul Slavin, VP Executive and Corporate HR Services

Acknowledged and accepted:

/s/ Keith B. Pitts
Signature

Date: 6/24, 2013

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Addendum

Responsibilities of Vice-Chairman:

A. Primary responsibilities:

1. Responsible for sourcing, evaluating, and executing material mergers, acquisitions, divestitures, investments, joint ventures and similar corporate development activities across Tenet's business lines

2. Management responsibility for Tenet's current acquisitions and development department

3. Member of Tenet's Senior Operating Committee (top corporate officers)

4. Advisor on strategies to Tenet's CEO

5. Member of the board of managers (equivalent to board of directors) of Conifer

6. Represent Tenet as a director of the Federation of American Hospitals and other national-level industry or business organizations

7. Participate in all Tenet board meetings

8. Co-Chair of Tenet's Capital Expenditure Review Committee ("CERC")(1)

B. Extensive involvement in the following areas, in coordination with functional leaders:

1. Investor relations (i.e., represent Tenet at selected investor conferences or road shows, in coordination with CFO and SVP of IR)

2. Government relations (in coordination with SVP Public Affairs)

3. Industry relations (i.e., represent Tenet at industry conferences, C-level industry meetings, or other venues, in coordination with SVP Public Affairs)

(1) This management committee approves key investments/expenditures greater than $5 million.

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Exhibit 21

Tenet Subsidiaries List
(As of 12/31/13)

All of the subsidiaries listed below are 100% owned by **Tenet Healthcare Corporation** unless otherwise indicated.

Conifer Holdings, Inc.
- (a) Conifer Ethics and Compliance, Inc.
- (a) Conifer Health Solutions, LLC — *ownership — Conifer Holdings, Inc., managing member (98%); Catholic Health Initiatives (2%)*
  - (b) Conifer Patient Communications, LLC
  - (b) Conifer Revenue Cycle Solutions, LLC
    - (c) Conifer HIM & Revenue Integrity Services, LLC
    - (c) Syndicated Office Systems, LLC
    - (c) Hospital RCM Services, LLC
    - (c) United Patient Financing, Inc.
  - (b) Conifer Value-Based Care, LLC
    - (c) InforMed Medical Management Services, LLC
    - (c) InforMed Insurance Services, LLC

DigitalMed, Inc.

National Imaging Center Holdings, Inc.
- (a) DMC Imaging, L.L.C.

National Surgery Center Holdings, Inc.
- (a) Bluffton Okatie Surgery Center, L.L.C.
- (a) Coral Ridge Outpatient Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
- (a) El Paso Day Surgery, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (61%); other outside members (39%)*
- (a) GCSA Ambulatory Surgery Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
- (a) Murdock Ambulatory Surgical Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
- (a) NSCH/USP Desert Surgery Centers, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (50.1%); Surgical Health Partners, Inc. (49.9%)*
  - (b) El Mirador Surgery Center, L.L.C. — *ownership — NSCH/USP Desert Surgery Centers, LLC, managing member (77.93%); other outside members (22.07%)*
- (a) Pacific Endoscopy and Surgery Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (55%); other outside members (45%)*
- (a) Pediatric Surgery Center - Odessa, LLC— *ownership — National Surgery Center Holdings, Inc., managing member (60%); other outside members (40%)*
- (a) Pediatric Surgery Centers, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (60%); other outside members (40%)*
- (a) South Florida Ambulatory Surgical Center, LLC — *ownership — National Surgery Center Holdings, Inc. (50.65%); other outside physician partners (49.35%)*
- (a) Surgery Center of Okeechobee, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
- (a) Surgery Center of Pembroke Pines, L.L.C. — *ownership — National Surgery Center Holdings, Inc., managing member (67.5%); other outside members (32.5%)*
- (a) The Surgery Center at Jensen Beach, LLC— *ownership — National Surgery Center Holdings, Inc., managing member (53.5%); other outside members (46.5%)*
- (a) Theda Oaks Gastroenterology & Endoscopy Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
- (a) Winter Haven Ambulatory Surgical Center, L.L.C. — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*

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National Urgent Care Holdings, Inc.
- (a) AMC/North Fulton Urgent Care #1, L.L.C.
- (a) AMC/North Fulton Urgent Care #2, L.L.C.
- (a) AMC/North Fulton Urgent Care #3, L.L.C.
- (a) AMC/North Fulton Urgent Care #4, L.L.C.
- (a) AMC/North Fulton Urgent Care #5, L.L.C.
- (a) AMC/North Fulton Urgent Care #6, L.L.C.
- (a) Camp Creek Urgent Care, L.L.C.
- (a) Des Peres Urgent Care, L.L.C.
- (a) Memphis Urgent Care #1, L.L.C.
- (a) Memphis Urgent Care #2, L.L.C.
- (a) NUCH of Georgia, L.L.C.
- (a) NUCH of Texas
- (a) Olive Branch Urgent Care #1, LLC
- (a) Selma Carlson, Inc.
- (a) St. Louis Urgent Care #2, L.L.C.
- (a) St. Louis Urgent Care #3, L.L.C.
- (a) Walker Street Imaging Care, Inc.
- (a) West Boynton Urgent Care, L.L.C.

NME Headquarters, Inc.

NME Properties Corp.
- (a) NME Properties, Inc.
  - (b) Lake Health Care Facilities, Inc.
- (a) NME Property Holding Co., Inc.
- (a) Tenet HealthSystem SNF-LA, Inc.

NME Psychiatric Hospitals, Inc.
- (a) The Huron Corporation

NME Rehabilitation Properties, Inc.
- (a) R.H.S.C. El Paso, Inc.

TenetCare, Inc.
- (a) National Diagnostic Imaging Centers, Inc.
- (a) TenetCare Frisco, Inc.
  - (b) Centennial ASC, L.P. *(1% GP: TenetCare Frisco, Inc.; 99% LP: Tenet Hospitals Limited)*
- (a) TenetCare Tennessee, Inc.

Tenet Healthcare Foundation

Tenet HealthSystem Holdings, Inc.
- (a) Tenet HealthSystem Medical, Inc.
  - (b) 601 N 30th Street III, Inc.
    - (c) 601 N 30th Street I, L.L.C. — *ownership — 601 N 30th Street III, Inc. (74.06%) Tenet HealthSystem Medical, Inc. (25.94%)*
      - (d) 601 N 30th Street II, L.L.C.
  - (b) American Medical (Central), Inc.
    - (c) Amisub (Heights), Inc.
    - (c) Amisub (Twelve Oaks), Inc.
    - (c) Lifemark Hospitals, Inc.
      - (d) Amisub of Texas, Inc.
      - (d) Houston Network, Inc.
      - (d) Houston Specialty Hospital, Inc.
      - (d) Lifemark Hospitals of Florida, Inc.
        - (e) Surgicare of Miramar, L.L.C. — *ownership — Lifemark Hospitals of Florida, Inc., managing member (50.97%); other outside members (49.03%)*

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(d) Lifemark Hospitals of Louisiana, Inc.
(d) TH Healthcare, Ltd. — *ownership — GP: Lifemark Hospitals, Inc. (1%); LP: Amisub of Texas, Inc. (70.1%); LP: Amisub (Heights), Inc. (10.3%); LP: Amisub (Twelve Oaks), Inc. (18.6%)*
(e) Park Plaza Hospital Billing Center, L.L.C.
(c) Tenet Employment, Inc.
(b) AMI Diagnostic Services, Inc.
(b) AMI Information Systems Group, Inc.
(b) AMI/HTI Tarzana Encino Joint Venture — *ownership — Tenet HealthSystem Medical, Inc. (30%) Amisub of California, Inc. (26%); New H Acute, Inc. (12%) AMI Information Systems Group, Inc. (7%)*
(b) Amisub (Hilton Head), Inc.
(c) Hilton Head Health System, L.P. — *ownership — Amisub (Hilton Head), Inc. (79%) Tenet Physician Services - Hilton Head, Inc. (21%)*
(b) Amisub (North Ridge Hospital), Inc.
(c) NRMC Physician Services, L.L.C.
(b) Amisub (SFH), Inc.
(c) Saint Francis Hospital Billing Center, L.L.C.
(c) Saint Francis Surgery Center, L.L.C. *(60.6061% member interest)*
(c) Tenet HealthSystem SF-SNF, Inc.
(b) Amisub of California, Inc.
(b) Amisub of North Carolina, Inc.
(c) Central Carolina Ambulatory Surgery Center, LLC
(b) Amisub of South Carolina, Inc.
(c) Rock Hill Surgery Center, L.P. — *ownership — Amisub of South Carolina, Inc. (72%) Surgical Center of Rock Hill (28%)*
(c) Tenet Rehab Piedmont, Inc.
(b) Brookwood Center Development Corporation
(c) Alabama Digestive Health Endoscopy Center, L.L.C. *(53% member interest)*
(c) Brookwood Home Health, LLC — *ownership — Brookwood Center Development Corporation (51%); other outside member (49%)*
(c) BWP Associates, Ltd. — *ownership — Brookwood Center Development Corporation (80%) Brookwood Development, Inc. (20%)*
(c) C.K. of Birmingham, LLC
(c) Hoover Doctors Group, Inc.
(c) Medplex Outpatient Medical Centers, Inc.
(c) Medplex Outpatient Surgery Center, Ltd. — *ownership — Others (15%) Brookwood Center Development Corporation (8% GP, 73.765% LP); Hoover Doctors Group, Inc. (1% LP); Medplex Outpatient Medical Centers, Inc. (1% LP)*
(b) Brookwood Development, Inc.
(b) Brookwood Health Services, Inc.
(c) Brookwood Garages, L.L.C.
(b) Brookwood Parking Associates, Ltd. — *ownership — Tenet HealthSystem Medical, Inc. (99%), Brookwood Garages, L.L.C. (1%)*
(b) Coastal Carolina Medical Center, Inc.
(c) Coastal Carolina Pro Fee Billing, L.L.C.
(b) Coastal Carolina Physician Practices, L.L.C.
(c) Hardeeville Medical Group, L.L.C.
(c) Hardeeville Primary Care, L.L.C.
(b) Cumming Medical Ventures, Inc.
(b) East Cooper Community Hospital, Inc.
(c) The Southeastern Spine Institute Surgery Center, L.L.C. — *ownership — East Cooper Community Hospital, Inc., managing member (55%); other outside members (45%)*
(b) Eastern Professional Properties, Inc.
(b) Frye Regional Medical Center, Inc.
(c) FryeCare Outpatient Imaging, L.L.C.

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(c) Frye Heart Excellence Team, LLC *(50% member interest)*
(c) Frye Home Infusion, Inc.
(c) Guardian Health Service, L.L.C. *(50% member interest)*
(c) Tate Surgery Center, L.L.C.
(c) Unifour Neurosurgery, L.L.C.
(c) Viewmont Surgery Center, L.L.C.
(b) Magnetic Resonance Imaging of San Luis Obispo, Inc.
(b) New H Acute, Inc.
(b) North Fulton Medical Center, Inc.
(c) Endoscopy Consultants, LLC — *ownership — North Fulton Medical Center, Inc. (51%); other outside physician partners (49%)*
(c) Georgia Center, LLC — *ownership — North Fulton Medical Center, Inc. (51%); other outside physician partners (49%)*
(c) North Fulton GI Center, L.L.C.
(c) Northwoods Surgery Center, LLC
(c) NorthPoint Health System, Inc.
(c) Northwoods Member, Inc.
(c) Roswell Georgia Surgery Center, L.L.C.
(b) North Fulton MOB Ventures, Inc.
(b) Palm Beach Gardens Community Hospital, Inc.
(c) Palm Beach Gardens Cardiac and Vascular Partners, LLC — *ownership — Palm Beach Gardens Community Hospital, Inc. (50%); other outside physician partners (50%)*
(b) Piedmont Urgent Care and Industrial Health Centers, Inc.
(c) Catawba-Piedmont Cardiothoracic Surgery, L.L.C.
(c) Imaging Center at Baxter Village, L.L.C.
(c) Piedmont Behavioral Medicine Associates, LLC
(c) Piedmont Cardiovascular Physicians, L.L.C.
(c) Piedmont Carolina OB/GYN of York County, L.L.C.
(c) Piedmont Carolina Vascular Surgery, L.L.C.
(c) Piedmont East Urgent Care Center, L.L.C.
(c) Piedmont Express Care at Sutton Road, L.L.C.
(c) Piedmont Family Practice at Baxter Village, L.L.C.
(c) Piedmont Family Practice at Rock Hill, L.L.C.
(c) Piedmont Family Practice at Tega Cay, L.L.C.
(c) Piedmont General Surgery Associates, L.L.C.
(c) Piedmont Internal Medicine at Baxter Village, L.L.C.
(c) Piedmont Internal Medicine and Family Practice at York, L.L.C.
(c) Piedmont Pulmonology, L.L.C.
(c) Piedmont Surgical Specialists, L.L.C.
(c) Piedmont Urgent Care Center at Baxter Village, LLC
(c) Piedmont West Urgent Care Center, L.L.C.
(c) Sutton Road Pediatrics, L.L.C.
(b) Physician Performance Network, L.L.C.
(c) Physician Performance Network of Georgia, L.L.C.
(c) Physician Performance Network of Philadelphia, L.L.C.
(b) Professional Healthcare Systems Licensing Corporation
(b) Roswell Medical Ventures, Inc.
(c) North Fulton Parking Deck, L.P. — *ownership — Roswell Medical Ventures, Inc. (89.836%), other outside partners (10.164%)*
(b) Sierra Vista Hospital, Inc.
(b) South Carolina Health Services, Inc.
(c) Bluffton Okatie Primary Care, L.L.C.
(c) Broad River Primary Care, L.L.C.
(c) Burnt Church Primary and Urgent Care, L.L.C.
(c) Cardiovascular & Thoracic Surgery Associates, L.L.C.
(c) Okatie Surgical Partners, L.L.C.
(c) Hardeeville Hospitalists, L.L.C.

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- (c) Heritage Medical Group of Hilton Head, L.L.C.
- (c) Hilton Head Occupational Medicine, L.L.C.
- (c) Hilton Head Regional Anesthesia Partners, L.L.C.
- (c) Hilton Head Regional Endocrinology Associates, L.L.C.
- (c) Hilton Head Regional OB/GYN Partners, L.L.C.
- (c) Mid-Island Primary and Urgent Care, L.L.C.
- (c) Nephrology Associates of Hilton Head, L.L.C.
- (c) Oncology Associates of the Low Country, L.L.C.
- (c) Orthopedic Associates of the Lowcountry, L.L.C.
- (c) Tenet Hilton Head Heart, L.L.C.
- (c) Tenet South Carolina Lowcountry OB/GYN, L.L.C.

(b) Tenet Central Carolina Physicians, Inc.
(b) Tenet DISC Imaging, Inc.
(b) Tenet EKG, Inc.
(b) Tenet Finance Corp.
(b) Tenet Good Samaritan, Inc.

- (c) Good Samaritan Surgery, L.L.C.
- (c) Good Samaritan Cardiac & Vascular Management, LLC — *ownership — Tenet Good Samaritan, Inc. (50%); other outside physician partners (50%)*

(b) Tenet HealthSystem Bartlett, Inc.
(b) Tenet HealthSystem GB, Inc.

- (c) AMC Acquisition Company, L.L.C.
- (c) AMC Community Physician Practices, L.L.C.
- (c) Atlanta Medical Billing Center, L.L.C.
- (c) Sheffield Educational Fund, Inc.
- (c) Tenet South Fulton Health Care Centers, Inc.

(b) Tenet HealthSystem Nacogdoches ASC GP, Inc.

- (c) NMC Lessor, L.P. — *ownership — GP: Tenet HealthSystem Nacogdoches ASC GP, Inc. (1%); LP: TH Healthcare, Ltd. (99%)*
- (c) NMC Surgery Center, L.P. — *ownership — Tenet HealthSystem Nacogdoches ASC GP, Inc. (1% GP); Tenet HealthSystem Nacogdoches ASC, LP, Inc. (58.999% LP); other outside partners (49.001% LP)*

(b) Tenet HealthSystem Nacogdoches ASC LP, Inc.
(b) Tenet HealthSystem North Shore, Inc.

- (c) North Shore Medical Billing Center, L.L.C.
- (c) North Shore Physician Hospital Organization *(50%)*
- (c) North Shore Physician Practices, L.L.C.

(b) Tenet HealthSystem Philadelphia, Inc.

- (c) HPS of PA, L.L.C.
- (c) Tenet HealthSystem Bucks County, L.L.C.
- (c) Tenet HealthSystem City Avenue, L.L.C.
- (c) Tenet HealthSystem Elkins Park, L.L.C.
- (c) Tenet HealthSystem Graduate, L.L.C.
- (c) Tenet HealthSystem Hahnemann, L.L.C.
- (c) Tenet HealthSystem Parkview, L.L.C.
- (c) Tenet HealthSystem Roxborough, LLC
- (c) Tenet HealthSystem Roxborough MOB, LLC
- (c) Tenet HealthSystem St. Christopher's Hospital for Children, L.L.C.
  - (d) Center for the Urban Child, Inc.
  - (d) SCHC Pediatric Anesthesia Associates, L.L.C.
  - (d) SCHC Pediatric Associates, L.L.C.
    - (e) St. Christopher's Pediatric Urgent Care Center, L.L.C.
    - (e) St. Christopher's Pediatric Urgent Care Center - Allentown, L.L.C.
  - (d) StChris Care at Northeast Pediatrics, L.L.C.
- (c) Tenet Home Services, L.L.C.
- (c) Tenet Medical Equipment Services, L.L.C.
- (c) The Healthcare Underwriting Company, a Risk Retention Group
- (c) TPS of PA, L.L.C.

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(d) TPS II of PA, L.L.C.
(d) TPS III of PA, L.L.C.
(d) TPS IV of PA, L.L.C.
(d) TPS V of PA, L.L.C.
(d) TPS VI of PA, L.L.C.
(c) MidAtlantic MedEvac, L.L.C.
(b) Tenet HealthSystem SGH, Inc.
(b) Tenet HealthSystem SL, Inc.
(c) SLUH Anesthesia Physicians, L.L.C.
(c) Tenet SLUH Physicians, L.L.C.
(b) Tenet HealthSystem SL-HLC, Inc.
(b) Tenet HealthSystem Spalding, Inc.
(c) Griffin Imaging, LLC — *ownership — Tenet HealthSystem Spalding, Inc., managing member (50.5%); other outside members (49.5%)*
(c) Spalding GI, L.L.C.
(c) Spalding Health System, L.L.C. — *ownership — (49.836%)*
(c) Spalding Medical Ventures, L.P.
(c) Tenet EMS/Spalding 911, LLC — *ownership — (64.1%)*
(b) Tenet Healthcare - Florida, Inc.
(b) Tenet Investments, Inc.
(b) Tenet Physician Services - Hilton Head, Inc.
(b) Tenet Practice Resources, LLC
(b) Tenet St. Mary's, Inc.
(c) The Heart and Vascular Clinic, L.L.C.
(b) Tenet Ventures, Inc.
(b) Tenet West Palm Real Estate, Inc.
(c) G.S. North, Ltd. — *ownership — (1% GP and 93.03% LP)*

Tenet HealthSystem Hospitals, Inc.
(a) Alvarado Hospital Medical Center, Inc.

Tenet HealthSystem HealthCorp
(a) OrNda Hospital Corporation
(b) AHM Acquisition Co., Inc.
(b) Commonwealth Continental Health Care, Inc.
(b) Coral Gables Hospital, Inc.
(c) CGH Hospital, Ltd. — *ownership — GP: Coral Gables Hospital, Inc. (99.913%) LP: FMC Medical, Inc. (0.087%)*
(d) Coral Gables Physician Services, L.L.C.
(d) Universal Medical Care Center, L.L.C.
(b) Cypress Fairbanks Medical Center, Inc.
(c) New Medical Horizons II, Ltd. — *ownership — GP: Cypress Fairbanks Medical Center, Inc. (5%) LP: Tenet HealthSystem CFMC, Inc. (95%)*
(b) FMC Medical, Inc.
(b) Fountain Valley Regional Hospital and Medical Center
(c) Specialty Surgery Center at Fountain Valley Regional Hospital, L.L.C. — *ownership — Fountain Valley Regional Hospital and Medical Center (51%); other outside members (49%)*
(b) GCPG, Inc.
(c) Garland MOB Properties, LLC
(b) Gulf Coast Community Hospital, Inc.
(c) Gulf Coast Community Health Care Systems, Inc.
(b) Houston Northwest Medical Center, Inc.
(c) HNMC, Inc.
(d) HNW GP, Inc.
(e) Houston Northwest Partners, Ltd. — *ownership — GP: HNW GP, Inc. (1%) LP: HNW LP, Inc. (99%)*

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(f) Conroe Surgery Center 2, LLC — *ownership — Houston Northwest Partners, Ltd. managing member (50.89%); other outside members (49.11%)*
(f) Houston Northwest Operating Company, L.L.C. — *ownership — Houston Northwest Partners, Ltd. (86.69%); other outside members (13.31%)*
(g) Houston Northwest Concessions, L.L.C.
(f) Northwest Surgery Center, Ltd — *ownership — Houston Northwest Partners, Ltd. (51%); other outside partners (49%)*
(d) HNW LP, Inc.
(c) Northwest Houston Providers Alliance, Inc.
(b) Newhope Imaging Center, Inc.
(b) NWSC, L.L.C.
(b) Republic Health Corporation of Rockwall County
(c) Lake Pointe GP, Inc.
(d) Lake Pointe Partners, Ltd. — *ownership — GP: Lake Pointe GP, Inc. (1%); LP: Lake Pointe Investments, Inc. (99%)*
(e) Lake Pointe Operating Company, L.L.C. — *ownership — Lake Pointe Partners, Ltd. (94.674%); other outside members (5.326%)*
(f) Billing Center Lake Pointe Medical, L.L.C.
(c) Lake Pointe ASC GP, Inc.
(c) Lake Pointe Investments, Inc.
(d) Lake Pointe Rockwall ASC, LP — *ownership — GP: Lake Pointe Rockwall ASC GP, Inc. (1%); LP: Lake Pointe Investments, Inc. (99%)*
(b) RHC Parkway, Inc.
(c) North Miami Medical Center, Ltd. — *ownership — RHC Parkway, Inc. (85.91%) Commonwealth Continental Health Care, Inc. (14.09%)*
(b) Saint Vincent Healthcare System, Inc.
(c) OHM Services, Inc.
(c) Saint Vincent Hospital, L.L.C.
(b) SHL/O Corp.
(b) Tenet HealthSystem CFMC, Inc.
(b) Tenet HealthSystem CM, Inc.
(a) Tenet MetroWest Healthcare System, Limited Partnership

Tenet HealthSystem International, Inc.
(a) N.M.E. International (Cayman) Limited
(b) HUG Services, Inc. — *ownership — N.M.E. International (Cayman) Limited (67%); Tenet Healthcare Corporation (30%); Tenet HealthSystem Medical, Inc. (3%)*
(c) Captive Insurance Services, Inc.
(c) Hospital Underwriting Group, Inc.
(d) Professional Liability Insurance Company
(a) The Healthcare Insurance Corporation

Tenet Hospitals, Inc.
(a) National ASC, Inc.
(a) Tenet Alabama, Inc.
(b) Brookwood Primary Network Care, Inc.
(c) Alabama Cardiovascular Associates, L.L.C.
(c) Alabama Hand and Sports Medicine, L.L.C.
(c) Brookwood - Maternal Fetal Medicine, L.L.C.
(c) Brookwood Medical Partners - ENT, L.L.C.
(c) Brookwood Occupational Health Clinic, L.L.C.
(c) Brookwood Primary Care Cahaba Heights, L.L.C.
(c) Brookwood Primary Care - Homewood, L.L.C.
(c) Brookwood Primary Care Hoover, L.L.C.
(c) Brookwood Primary Care - Inverness, L.L.C.
(c) Brookwood Primary Care - Mountain Brook, L.L.C.
(c) Brookwood Primary Care - Oak Mountain, L.L.C.
(c) Brookwood Primary Care - Red Mountain, L.L.C.
(c) Brookwood Primary Care The Narrows, L.L.C.

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(c) Brookwood Primary Care - Trussville, L.L.C.
(c) Brookwood Primary Care - Vestavia, L.L.C.
(c) Brookwood Primary Care Network - McCalla, L.L.C.
(c) Brookwood Sports and Orthopedics, L.L.C.
(c) Brookwood Specialty Care - Endocrinology, L.L.C.
(c) Brookwood Women's Care, L.L.C.
(c) Cardiovascular Associates of the Southeast, L.L.C.
(c) Greystone Internal Medicine - Brookwood, L.L.C.
(c) Norwood Clinic of Alabama, L.L.C.
(b) Brookwood Retail Pharmacy, L.L.C.

(a) Tenet California, Inc.
(b) Anaheim MRI Holding, Inc.
(b) Community Hospital of Los Gatos, Inc.
(c) Los Gatos Multi-Specialty Group, Inc.
(b) Doctors Hospital of Manteca, Inc.
(b) Doctors Medical Center of Modesto, Inc.
(c) Modesto On-Call Services, L.L.C.
(c) Modesto Radiology Imaging, Inc.
(c) Yosemite Medical Clinic, Inc.
(b) First Choice Physician Partners
(b) Golden State Medicare Health Plan
(b) JFK Memorial Hospital, Inc.
(c) SSC Holdings, L.L.C.
(b) Lakewood Regional Medical Center, Inc.
(b) Los Alamitos Medical Center, Inc.
(c) Reagan Street Surgery Center, L.L.C. — *ownership — Los Alamitos Medical Center, Inc (52%); other outside members (48%)*
(b) National Medical Ventures, Inc.
(b) Network Management Associates, Inc.
(b) PHPS-CHM Acquisition, Inc.
(c) Coast Healthcare Management, LLC
(c) Premier Health Plan Services, Inc.
(b) Placentia-Linda Hospital, Inc.
(c) Anaheim Hills Medical Imaging, L.L.C.
(b) San Ramon ASC, L.P.
(b) San Ramon Surgery Center, L.L.C.
(b) SRRMC Management, Inc.
(c) San Ramon Network Joint Venture, LLC — *ownership — SRRMC Management, Inc (51%); John Muir Health (49%)*
(d) San Ramon Ambulatory Care, LLC
(c) San Ramon Regional Medical Center, LLC — *ownership — SRRMC Management, Inc (51%); John Muir Health (49%)*
(d) Pleasanton Diagnostic Imaging, Inc.
(b) Tenet California Nurse Resources, Inc.
(b) Tenet California Medical Ventures I, Inc.
(b) Tenet El Mirador Surgical Center, Inc.
(b) Tenet HealthSystem Desert, Inc.
(b) Tenet HealthSystem KNC, Inc.
(b) Twin Cities Community Hospital, Inc.
(c) Templeton Imaging, Inc.

(a) Tenet Florida, Inc.
(b) Advantage Health Network, Inc. — *ownership — Tenet Florida, Inc. (50%); other outside members (50%)*
(b) Delray Medical Center, Inc.
(b) Florida Regional Medical Center, Inc.
(b) FMCC Network Contracting, L.L.C.
(b) FREH Real Estate, L.L.C.
(b) FRS Imaging Services, L.L.C.
(b) Hollywood Medical Center, Inc.

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- (b) International Health and Wellness, Inc.
- (b) National Medical Services II, Inc.
- (b) National Urgent Care, Inc.
- (b) Tenet Florida Physician Services, L.L.C.
  - (c) Center for Advanced Research Excellence, L.L.C.
  - (c) Sunrise Medical Group I, L.L.C.
  - (c) Sunrise Medical Group II, L.L.C.
  - (c) Sunrise Medical Group III, L.L.C.
  - (c) Sunrise Medical Group IV, L.L.C.
  - (c) Sunrise Medical Group V, L.L.C.
  - (c) Sunrise Medical Group VI, L.L.C.
  - (c) Tenet Florida Physician Services II, L.L.C.
  - (c) Tenet Florida Physician Services III, L.L.C.
- (b) Tenet Hialeah HealthSystem, Inc.
  - (c) Hialeah Real Properties, Inc.
  - (c) Tenet Hialeah (ASC) HealthSystem, Inc.
- (b) Tenet Network Management, Inc.
- (b) West Boca Medical Center, Inc.
  - (c) West Boca Health Services, L.L.C.

(a) Tenet Georgia, Inc.
- (b) AMC Neurosurgical Associates, L.L.C.
- (b) Atlanta Medical Center Interventional Neurology Associates, L.L.C.
- (b) Atlanta Medical Center Neurosurgical & Spine Specialists, L.L.C.
- (b) Atlanta Medical Center Physician Group, L.L.C.
- (b) Buckhead Orthopedic Surgery Center, L.L.C.
- (b) Gastric Health Institute, L.L.C.
- (b) Georgia Gifts From Grace, L.L.C.
- (b) Georgia North Fulton Healthcare Associates, L.L.C.
- (b) Georgia Northside Ear, Nose and Throat, L.L.C.
- (b) Georgia Spectrum Neurosurgical Specialists, L.L.C.
- (b) Jackson Medical Center, L.L.C.
- (b) North Fulton Cardiovascular Medicine, L.L.C.
- (b) North Fulton Hospitalist Group, L.L.C.
- (b) North Fulton Primary Care Associates, L.L.C.
- (b) North Fulton Primary Care - Windward Parkway, L.L.C.
- (b) North Fulton Primary Care - Wylie Bridge, L.L.C.
- (b) North Fulton Pulmonary Specialists, L.L.C.
- (b) North Fulton Regional Medical Center Pro Fee Billing, L.L.C.
- (b) North Fulton Women's Consultants, L.L.C.
- (b) Rock Bridge Surgical Institute, L.L.C.
- (b) Roswell Orthopedic Specialists, L.L.C.
- (b) Rheumatology Associates of Atlanta Medical Center, L.L.C.
- (b) Spalding Regional Ambulatory Surgery Center, L.L.C.
- (b) Spalding Regional OB/GYN, L.L.C.
- (b) Spalding Regional Physician Services, L.L.C.
- (b) Spalding Regional Urgent Care Center at Heron Bay, L.L.C.
- (b) SouthCare Physicians Group Neurology, L.L.C.
- (b) SouthCare Physicians Group Obstetrics & Gynecology, L.L.C.
- (b) South Fulton Regional Medical Center Pro Fee Billing, L.L.C.
- (b) Surgical & Bariatric Associates of Atlanta Medical Center, L.L.C.

(a) Total Health PPO, Inc. — o*wnership — Tenet Hospitals, Inc (49%); HealthScope (51%)*

(a) Tenet Louisiana, Inc.
- (b) Meadowcrest Hospital, LLC
- (b) Meadowcrest Multi-Specialty Clinic, L.L.C.
- (b) Tenet 100 Medical Center Slidell, L.L.C.
- (b) Tenet HealthSystem Memorial Medical Center, Inc.
  - (c) Tenet Mid-City Medical, LLC

(a) Tenet Missouri, Inc.

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(b) Cedar Hill Primary Care, L.L.C.
(b) Premier Emergency Physicians, L.L.C.
(b) Premier Medical Specialists, L.L.C.
(b) St. Louis University Hospital Ambulatory Surgery Center, L.L.C.
(b) Tenet HealthSystem DI, Inc.
(c) Bridgeton Imaging, L.L.C.
(c) U.S. Center for Sports Medicine, L.L.C.
(a) Tenet Nebraska, Inc.
(a) Tenet North Carolina, Inc.
(b) Cardiology Physicians Associates, L.L.C.
(b) Cardiology Physicians Corporation, L.L.C.
(b) Central Carolina-CIM, L.L.C.
(b) Central Carolina-IMA, L.L.C.
(b) Central Carolina Hospital Pro Fee Billing, L.L.C.
(b) Central Carolina Physicians - Sandhills, L.L.C.
(b) FryeCare Appalachian, L.L.C.
(b) FryeCare Boone, L.L.C.
(b) FryeCare Morganton, L.L.C.
(b) FryeCare Northwest Hickory, L.L.C.
(b) FryeCare Physicians, L.L.C.
(b) FryeCare Valdese, L.L.C.
(b) FryeCare Watauga, L.L.C.
(b) FryeCare Women's Services, L.L.C.
(b) Frye Physicians - Tenet NC, L.L.C.
(b) Graystone Family Healthcare - Tenet North Carolina, L.L.C.
(b) Hallmark Family Physicians - Tenet North Carolina, L.L.C.
(b) Healthpoint of North Carolina, L.L.C.
(b) Hickory Family Practice Associates - Tenet North Carolina, L.L.C.
(b) North Carolina Community Family Medicine, L.L.C.
(b) Parkway Internal Medicine - Tenet North Carolina, L.L.C.
(b) Southern States Physician Operations, Inc.
(b) Tenet Claremont Family Medicine, L.L.C.
(b) Tenet Unifour Urgent Care Center, L.L.C.
(b) Viewmont Internal Medicine - Tenet North Carolina, L.L.C.
(a) Tenet Physicians, Inc.
(a) Tenet South Carolina, Inc.
(b) East Cooper Coastal Family Physicians, L.L.C.
(b) East Cooper Hyperbarics, L.L.C.
(b) East Cooper OBGYN, L.L.C.
(b) East Cooper Primary Care Physicians, L.L.C.
(b) Hilton Head Hospital Pro Fee Billing, L.L.C.
(b) Hilton Head Regional Healthcare, L.L.C.
(b) South Carolina East Cooper Surgical Specialists, L.L.C.
(b) South Carolina SeWee Family Medicine, L.L.C.
(b) Southern Orthopedics and Sports Medicine, L.L.C.
(b) Tenet Fort Mill, Inc.
(b) Tenet SC East Cooper Hospitalists, L.L.C.
(b) Tenet South Carolina Gastrointestinal Surgical Specialists, L.L.C.
(b) Tenet South Carolina Island Medical, L.L.C.
(b) Tenet South Carolina Mt. Pleasant OB/GYN, L.L.C.
(a) Tenet Tennessee, Inc.
(b) Saint Francis Behavioral Health Associates, L.L.C.
(b) Saint Francis Cardiology Associates, L.L.C.
(b) Saint Francis Cardiovascular Surgery, L.L.C.
(b) Saint Francis Center for Surgical Weight Loss, L.L.C.
(b) Saint Francis Hospital Inpatient Physicians, L.L.C.
(b) Saint Francis Hospital Pro Fee Billing, L.L.C.
(b) Saint Francis Medical Partners, East, L.L.C.

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(b) Saint Francis Medical Specialists, L.L.C.
(b) Saint Francis Surgical Associates, L.L.C.
(a) Tenet Texas, Inc.
(b) Eastside ASC GP, Inc.
(c) Eastside Surgery, L.P.
(b) EPHC, Inc.
(b) Greater Dallas Healthcare Enterprises
(b) Greater Northwest Houston Enterprises
(b) Houston Sunrise Investors, Inc.
(b) National Ancillary, Inc.
(b) National HHC, Inc.
(b) National ICN, Inc.
(b) Physicians Performance Network of Houston
(b) Practice Partners Management, L.P. — *ownership — GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(b) Sierra Providence Healthcare Enterprises
(b) Sierra Providence Health Network, Inc.
(b) Tenet El Paso, Ltd. — ownership — *GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(b) Tenet Frisco, Ltd. — *ownership — GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(b) Tenet HealthSystem Hospitals Dallas, Inc.
(b) Tenet Hospitals Limited — *ownership — GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(c) Billing Center Doctors Hospital at White Rock Lake, L.L.C.
(c) PDN, L.L.C.
(d) Surgery Affiliate of El Paso, LLC — *ownership — PDN, LLC, managing member (61%); other outside members (39%)*
(c) Tenet Sun View Imaging, L.L.C.
(b) Tenet Relocation Services, L.L.C.
(b) Tenetsub Texas, Inc.

T.I. GPO, Inc.

Vanguard Health Systems, Inc.
(a) Vanguard Health Holding Company I, LLC
(b) Vanguard Holding Company I, Inc.
(b) Vanguard Health Holding Company II, LLC
(c) Vanguard Health Management, Inc.
(d) Harbor Health Plans, Inc.
(d) Vanguard Health Financial Company, LLC
(e) C7 Technologies, LLC
(e) Central Texas Corridor Hospital Company, LLC
(e) Hospital Development of West Phoenix, Inc.
(e) MacNeal Management Services, Inc.
(f) Chicago Health System ACO, LLC
(f) MacNeal Health Providers, Inc.
(f) Midwest Pharmacies, Inc.
(f) Primary Care Physicians Center, LLC - *ownership - MacNeal Management Services, Inc. (94% of capital interests) and Thomas Mizen (6% of capital interests)*
(f) Pros Temporary Staffing, Inc.
(f) The 6300 West Roosevelt Partnership - *ownership - MacNeal Management Services, Inc. 50.326% (29.876% GP interest and 20.450% LP interest) and numerous limited partners*
(f) Watermark Physician Services, Inc.
(e) MacNeal Medical Records, Inc.
(e) Resolute Hospital Company, LLC
(e) Southwest Children's Hospital, LLC
(e) V-II Acquisition Co., Inc.
(e) Valley Baptist Insurance Company

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(e) Vanguard IT Services, LLC
(e) VHS Acquisition Corporation
(e) VHS Acquisition Subsidiary Number 1, Inc.
(e) VHS Acquisition Subsidiary Number 2, Inc.
(e) VHS Acquisition Subsidiary Number 3, Inc.
  (f) LakeFront Medical Associates, LLC
(e) VHS Acquisition Subsidiary Number 4, Inc.
(e) VHS Acquisition Subsidiary Number 5, Inc. - *ownership - Vanguard Health Financial Company, LLC (100% voting common - 8,010 common shares) and Baptist Health Foundation of San Antonio (3,582 preferred)*
  (f) VHS San Antonio Imaging Partners, L.P. - *ownership - VHS Acquisition Subsidiary Number 5, Inc. General Partner (2%), Imaging Center Partners, L.P., Limited Partner (50%) and VHS San Antonio Partners, LLC, Limited Partner (48%)*
  (f) VHS San Antonio Partners, LLC - *ownership - VHS Acquisition Subsidiary Number 5, Inc., Managing Member (2%) and VHS Holding Company, Inc. (98%)*
    (g) Baptist Medical Management Service Organization, LLC
    (g) BHS Accountable Care, LLC
    (g) BHS Integrated Physician Partners, LLC
    (g) BHS Physicians Alliance For ACE, LLC
    (g) Home Health Partners of San Antonio, LLC
      (h) Journey Home Healthcare of San Antonio, LLC
(e) VHS Acquisition Subsidiary Number 6, Inc.
  (f) VHS Acquisition Partnership Number 1, L.P. - *ownership - VHS Acquisition Subsidiary Number 6, Inc., General Partner (2%) and VHS Holding Company, Inc., Limited Partner (98%)*
(e) VHS Acquisition Subsidiary Number 7, Inc.
  (f) Saint Vincent Physician Services, Inc.
(e) VHS Acquisition Subsidiary Number 8, Inc.
  (f) Community Connection Health Plan, Inc.
  (f) Advantage Health Care Management Company, LLC
(e) VHS Acquisition Subsidiary Number 9, Inc.
  (f) MetroWest Accountable Health Care Organization, LLC - *ownership - VHS Acquisition Subsidiary Number 9, Inc. (50%) and MetroWest Health Care Alliance, Inc. (50%)*
    (g) Total Accountable Care Organization, LLC - *ownership - MetroWest Accountable Health Care Organization, LLC (70%) and VHS Acquisition Subsidiary Number 7, Inc. (30%)*
  (f) VHM Services, Inc.
(e) VHS Acquisition Subsidiary Number 10, Inc.
(e) VHS Acquisition Subsidiary Number 11, Inc.
(e) VHS Acquisition Subsidiary Number 12, Inc.
(e) VHS Genesis Labs, Inc.
(e) VHS Holding Company, Inc.
  (f) BHS Physicians Network, Inc.
  (f) BHS Specialty Network, Inc.
    (g) Heart & Vascular Institute of Texas, Inc.
  (f) Resolute Health Family Urgent Care, Inc.
  (f) Resolute Health Physicians Network, Inc.
(e) VHS Imaging Centers, Inc.
(e) VHS New England Holding Company I, Inc.
(e) VHS of Illinois, Inc.
  (f) HCM/CV, LLC - *ownership - VHS of Illinois, Inc. (50%), HeartCare Centers of Illinois, S.C. (25%) and Cardiac Surgery Associates, S.C. (25%)*
  (f) MacNeal Physicians Group, LLC
  (f) Vanguard Medical Specialists, LLC
  (f) VHS Chicago Market Procurement, LLC
(e) VHS of Michigan, Inc.
  (f) CRNAS of Michigan

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(f) Detroit Education and Research
(f) DMC Education & Research
(f) Heart & Vascular Institute of Michigan
(f) Southeast Michigan Physicians Insurance Company
(f) VHS Children's Hospital of Michigan, Inc.
(f) VHS Detroit Businesses, Inc.
(f) VHS Detroit Receiving Hospital, Inc.
(f) VHS Detroit Ventures, Inc.
(g) DMC Shared Savings ACO, LLC
(g) Michigan Pioneer ACO, LLC - *ownership - VHS Detroit Ventures, Inc. (99.875%), George E. Evans (0.25%), Murtaza Hussain (0.25%), Muhammad Y. Karim (0.25%), Michael G. Taylor (0.25%) and Carl D. Fowler (0.25%)*
(f) VHS Harper-Hutzel Hospital, Inc.
(f) VHS Huron Valley-Sinai Hospital, Inc.
(f) VHS of Michigan Staffing, Inc.
(f) VHS Physicians of Michigan
(f) VHS Rehabilitation Institute of Michigan, Inc.
(f) VHS Sinai-Grace Hospital, Inc.
(f) VHS University Laboratories, Inc.

(e) VHS of Orange County, Inc.
(f) VHS Acquisition Partnership Number 2, L.P. - *ownership - VHS of Orange County, Inc., General Partner (1%), VHS of Orange County, Inc., Limited Partner (58.4%), VHS Holding Company, Inc., Limited Partner (35%), Physician Investors, Limited Partners (5.6%)*
(f) VHS of Anaheim, Inc.
(g) North Anaheim Surgicenter, Ltd. - *ownership - VHS of Anaheim, Inc., General Partner (76.5%) and Physician Investors, Limited Partners (23.5%)*
(f) VHS of Huntington Beach, Inc.
(g) Magnolia Surgery Center Limited Partnership - *ownership - VHS of Huntington Beach, Inc., General Partner (1%), VHS Holding Company, Inc., Limited Partner (82.6%) and Third Parties (physicians), Limited Partner (16.4%)*

(e) VHS of Phoenix, Inc.
(f) VHS Arizona Heart Institute, Inc.
(f) VHS of Arrowhead, Inc.
(f) VHS of South Phoenix, Inc.
(g) Arizona Health Partners, LLC
(g) Palm Valley Medical Center Campus Association - *ownership - VHS of South Phoenix, Inc. (72.38%), Palm Valley Med Bldg L.P. (Plaza) (5.72%), Palm Valley Med Bldg L.P. (Ruiz) (12.60%) and Palm Valley Nursing Facility L.P. (Nursing Home) (9.30%)*
(g) Phoenix Health Plans, Inc.
(h) VHS Phoenix Health Plan, LLC
(g) VHS Acquisition Company Number 1, LLC - *ownership - VHS of South Phoenix, Inc. (60%) and Medical Professional Associates of Arizona, P.C. (40%)*
(f) VHS Outpatient Clinics, Inc.
(g) Abrazo Medical Group Urgent Care, LLC

(e) VHS Valley Management Company, Inc.
(f) Harlingen Physician Network, Inc.
(f) Rio Grande Valley Indigent Health Care Corporation
(f) Valley Health Care Network
(f) VHS Valley Health System, LLC - *ownership - VHS Valley Management Company, Inc., Manager (51%) and VB Medical Holdings (49%)*
(g) VHS Brownsville Hospital Company, LLC
(g) VHS Harlingen Hospital Company, LLC
(g) Valley Baptist Realty Company, LLC
(g) VHS Valley Holdings, LLC
(h) Valley Baptist Lab Services, LLC
(h) Valley Baptist Wellness Center, LLC

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(h) VB Brownsville IMP ASC, LLC
(h) VB Brownsville LTACH, LLC
(h) VBOA ASC GP, LLC
(i) VBOA ASC Partners, L.P. - *ownership - VBOA ASC GP, LLC General Partner (1%), Various physicians, Class A Limited Partners (38%) and VB Brownsville IMP ASC, LLC, Class B Limited Partner (61%)*

(e) VHS West Suburban Medical Center, Inc.
(f) West Suburban Radiation Therapy Center, LLC
(e) VHS Westlake Hospital, Inc.
(e) VHS-Volunteer Insurance Ltd. (Cayman Islands Company)

(d) Vanguard Physician Services, LLC - *ownership - Vanguard Health Management, Inc. (60%) and MedSynergies, Inc. (40%)*
(d) Healthcare Compliance, L.L.C.
(d) New Dimensions, LLC

(c) Vanguard Holding Company II, Inc.

Wilshire Rental Corp.

(a) Hitchcock State Street Real Estate, Inc.

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Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement Nos. 33-55285, 33-57801, 333-21867, 333-24955, 333-26621, and 333-185162 on Form S-3, Registration Statement No. 333-191613 on Form S-4, and Registration Statement Nos. 33-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482, 333-74216, 333-151884, 333-151887, 333-166767, 333-166768 and 333-191614 on Form S-8 of our reports dated February 24, 2014, relating to the consolidated financial statements and financial statement schedule of Tenet Healthcare Corporation and subsidiaries, and the effectiveness of Tenet Healthcare Corporation and subsidiaries' internal control over financial reporting, appearing in this Annual Report on Form 10-K of Tenet Healthcare Corporation for the year ended December 31, 2013.

/s/ Deloitte & Touche LLP

Dallas, Texas
February 24, 2014

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Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Trevor Fetter, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 24, 2014

/s/ TREVOR FETTER
Trevor Fetter
President and Chief Executive Officer

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Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 24, 2014

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

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Exhibit 32

Certifications Pursuant to Section 1350 of Chapter 63
of Title 18 of the United States Code

We, the undersigned Trevor Fetter and Daniel J. Cancelmi, being, respectively, the President and Chief Executive Officer and the Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Annual Report on Form 10-K for the year ended December 31, 2013 (the "Form 10-K"), to be filed with the Securities and Exchange Commission on the date hereof, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and (ii) the information contained in the Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: February 24, 2014

/s/ TREVOR FETTER
Trevor Fetter
President and Chief Executive Officer

Date: February 24, 2014

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.

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EXHIBIT 16 – TENET'S 2014 2ND QUARTER 10-Q

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FORM 10-Q

TENET HEALTHCARE CORP - THC

Filed: August 04, 2014 (period: June 30, 2014)

Quarterly report with a continuing view of a company's financial position

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-Q

☒ **Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

for the quarterly period ended June 30, 2014

OR

☐ **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

for the transition period from to

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

Nevada	**95-2557091**
(State of Incorporation)	(IRS Employer Identification No.)

1445 Ross Avenue, Suite 1400
Dallas, TX 75202
(Address of principal executive offices, including zip code)

(469) 893-2200
(Registrant's telephone number, including area code)

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months, and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes ☒ No ☐

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Exchange Act Rule 12b-2).

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

As of July 31, 2014, there were 97,915,606 shares of the Registrant's common stock, $0.05 par value, outstanding.

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PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
Dollars in Millions
(Unaudited)

	June 30, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 406	$ 113
Accounts receivable, less allowance for doubtful accounts ($753 at June 30, 2014 and $589 at December 31, 2013)	2,171	1,965
Inventories of supplies, at cost	264	262
Income tax receivable	34	0
Current portion of deferred income taxes	633	581
Other current assets	700	789
Total current assets	**4,208**	**3,710**
Investments and other assets	362	405
Deferred income taxes, net of current portion	125	90
Property and equipment, at cost, less accumulated depreciation and amortization ($4,178 at June 30, 2014 and $3,898 at December 31, 2013)	7,771	7,691
Goodwill	3,200	3,042
Other intangible assets, at cost, less accumulated amortization ($618 at June 30, 2014 and $523 at December 31, 2013)	1,241	1,192
Total assets	**$ 16,907**	**$ 16,130**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 622	$ 149
Accounts payable	1,015	1,075
Accrued compensation and benefits	669	631
Professional and general liability reserves	162	156
Accrued interest payable	207	198
Other current liabilities	709	719
Total current liabilities	**3,384**	**2,928**
Long-term debt, net of current portion	10,942	10,690
Professional and general liability reserves	567	543
Defined benefit plan obligations	380	398
Other long-term liabilities	484	446
Total liabilities	**15,757**	**15,005**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	277	247
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 145,010,828 shares issued at June 30, 2014 and 144,057,351 shares issued at December 31, 2013	7	7
Additional paid-in capital	4,594	4,572
Accumulated other comprehensive loss	(20)	(24)
Accumulated deficit	(1,480)	(1,422)
Common stock in treasury, at cost, 47,196,972 shares at June 30, 2014 and 47,197,722 shares at December 31, 2013	(2,378)	(2,378)
Total shareholders' equity	**723**	**755**
Noncontrolling interests	**150**	**123**

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Total equity	**873**	**878**
Total liabilities and equity	**$ 16,907**	**$ 16,130**

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net operating revenues:				
Net operating revenues before provision for doubtful accounts	$ 4,362	$ 2,629	$ 8,668	$ 5,223
Less: Provision for doubtful accounts	320	207	700	414
Net operating revenues	**4,042**	**2,422**	**7,968**	**4,809**
Operating expenses:				
Salaries, wages and benefits	1,956	1,166	3,877	2,327
Supplies	649	387	1,277	771
Other operating expenses, net	1,035	567	2,034	1,135
Electronic health record incentives	(58)	(34)	(67)	(34)
Depreciation and amortization	209	121	402	235
Impairment and restructuring charges, and acquisition-related costs	32	11	53	25
Litigation and investigation costs	12	2	15	2
Operating income	**207**	**202**	**377**	**348**
Interest expense	(190)	(98)	(372)	(201)
Loss from early extinguishment of debt	0	(171)	0	(348)
Investment earnings	0	1	0	1
Income (loss) from continuing operations, before income taxes	**17**	**(66)**	**5**	**(200)**
Income tax benefit (expense)	(8)	20	(7)	73
Income (loss) from continuing operations, before discontinued operations	**9**	**(46)**	**(2)**	**(127)**
Discontinued operations:				
Income (loss) from operations	(7)	6	(15)	3
Litigation and investigation costs	(18)	0	(18)	0
Income tax benefit (expense)	9	(3)	12	(2)
Income (loss) from discontinued operations	**(16)**	**3**	**(21)**	**1**
Net loss	**(7)**	**(43)**	**(23)**	**(126)**
Less: Net income attributable to noncontrolling interests	19	7	35	12
Net loss attributable to Tenet Healthcare Corporation common shareholders	**$ (26)**	**$ (50)**	**$ (58)**	**$ (138)**
Amounts attributable to Tenet Healthcare Corporation common shareholders				
Loss from continuing operations, net of tax	$ (10)	$ (53)	$ (37)	$ (139)
Income (loss) from discontinued operations, net of tax	(16)	3	(21)	1
Net loss attributable to Tenet Healthcare Corporation common shareholders	**$ (26)**	**$ (50)**	**$ (58)**	**$ (138)**
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic				
Continuing operations	$ (0.11)	$ (0.52)	$ (0.38)	$ (1.34)
Discontinued operations	(0.16)	0.03	(0.22)	0.01
	$ (0.27)	**$ (0.49)**	**$ (0.60)**	**$ (1.33)**
Diluted				
Continuing operations	$ (0.11)	$ (0.52)	$ (0.38)	$ (1.34)
Discontinued operations	(0.16)	0.03	(0.22)	0.01
	$ (0.27)	**$ (0.49)**	**$ (0.60)**	**$ (1.33)**
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	97,677	103,010	97,419	103,557
Diluted	97,677	103,010	97,419	103,557

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME
Dollars in Millions
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net loss	$ (7)	$ (43)	$ (23)	$ (126)
Other comprehensive income:				
Amortization of prior-year service costs included in net periodic benefit costs	2	0	3	0
Unrealized gains on securities held as available-for-sale	3	0	3	0
Other comprehensive income before income taxes	**5**	**0**	**6**	**0**
Income tax expense related to items of other comprehensive income	(2)	0	(2)	0
Total other comprehensive income, net of tax	**3**	**0**	**4**	**0**
Comprehensive net loss	**(4)**	**(43)**	**(19)**	**(126)**
Less: Comprehensive income attributable to noncontrolling interests	**19**	**7**	**35**	**12**
Comprehensive net loss attributable to Tenet Healthcare Corporation common shareholders	**$ (23)**	**$ (50)**	**$ (54)**	**$ (138)**

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions
(Unaudited)

	Six Months Ended June 30,	
	2014	2013
Net loss	**$ (23)**	**$ (126)**
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	402	235
Provision for doubtful accounts	700	414
Deferred income tax benefit	(7)	(76)
Stock-based compensation expense	26	19
Impairment and restructuring charges, and acquisition-related costs	53	25
Litigation and investigation costs	15	2
Loss from early extinguishment of debt	0	348
Amortization of debt discount and debt issuance costs	14	9
Pre-tax (income) loss from discontinued operations	33	(3)
Other items, net	(9)	(18)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(937)	(445)
Inventories and other current assets	78	(166)
Income taxes	(17)	(4)
Accounts payable, accrued expenses and other current liabilities	(32)	(65)
Other long-term liabilities	47	5
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(84)**	**(19)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(12)**	**(7)**
Net cash provided by operating activities	**247**	**128**
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(523)	(256)
Purchases of businesses or joint venture interests, net of cash acquired	(42)	(16)
Proceeds from sales of marketable securities, long-term investments and other assets	3	3
Other long-term assets	(14)	6
Other items, net	0	3
Net cash used in investing activities	**(576)**	**(260)**
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(1,300)	(620)
Proceeds from borrowings under credit facility	895	653
Repayments of other borrowings	(68)	(1,967)
Proceeds from other borrowings	1,108	1,907
Repurchases of common stock	0	(192)
Deferred debt issuance costs	(19)	(30)
Distributions paid to noncontrolling interests	(20)	(10)
Contributions from noncontrolling interests	13	98
Proceeds from exercise of stock options	11	21
Other items, net	2	(2)

Source: TENET HEALTHCARE CORP, 10-Q, August 04, 2014
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Net cash provided by (used in) financing activities	**622**	**(142)**
Net increase (decrease) in cash and cash equivalents	293	(274)
Cash and cash equivalents at beginning of period	113	364
Cash and cash equivalents at end of period	**$ 406**	**$ 90**
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (360)	$ (226)
Income tax payments, net	$ (19)	$ (8)

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a national, diversified healthcare services company. As of June 30, 2014, we operated 79 hospitals, 189 outpatient centers, six health plans and Conifer Health Solutions, LLC ("Conifer"), which provides healthcare business process services in the areas of revenue cycle management, value-based care and patient communications.

Effective October 1, 2013, we acquired the common stock of Vanguard Health Systems, Inc. ("Vanguard") for $21 per share in an all cash transaction. Vanguard owned and operated 28 hospitals (plus one more under construction, which was recently completed), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas. We paid approximately $4.3 billion to acquire Vanguard, including the assumption of $2.5 billion of Vanguard's net debt.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2013 ("Annual Report"). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). Certain prior-year amounts have been adjusted to conform to the current-year presentation, including $73 million of Medicaid supplemental payments receivable that are now presented as other current assets rather than accounts receivable.

Although the Condensed Consolidated Financial Statements and related notes within this document are unaudited, we believe all adjustments considered necessary for a fair presentation have been included and are of a normal recurring nature. In preparing our financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP"), we must use estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Operating results for the three and six month periods ended June 30, 2014 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the number of covered lives managed by our health plans and the plans' ability to effectively manage medical costs; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; any unfavorable publicity about us, which impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

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Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e.,

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gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("Compact") and other uninsured discount and charity programs.

The table below shows the sources of net operating revenues before provision for doubtful accounts:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
General Hospitals:				
Medicare	$ 865	$ 502	$ 1,722	$ 1,042
Medicaid	380	236	672	424
Managed care	2,228	1,387	4,418	2,748
Indemnity, self-pay and other	368	261	815	521
Acute care hospitals — other revenue	18	11	37	39
Other:				
Other operations	503	232	1,004	449
Net operating revenues before provision for doubtful accounts	**$ 4,362**	**$ 2,629**	**$ 8,668**	**$ 5,223**

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $406 million and $113 million at June 30, 2014 and December 31, 2013, respectively. As of June 30, 2014 and December 31, 2013, our book overdrafts were approximately $144 million and $245 million, respectively, which were classified as accounts payable.

At June 30, 2014 and December 31, 2013, approximately $79 million and $62 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries.

Also at June 30, 2014 and December 31, 2013, we had $114 million and $193 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $64 million and $138 million, respectively, were included in accounts payable.

During the six months ended June 30, 2014 and 2013, we entered into non-cancellable capital leases of approximately $60 million and $79 million, respectively, primarily for buildings and equipment.

Other Intangible Assets

The following table provides information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets as of June 30, 2014 and December 31, 2013:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of June 30, 2014:			
Capitalized software costs	$ 1,385	$ (546)	$ 839
Long-term debt issuance costs	247	(44)	203
Trade names	81	0	81
Contracts	64	(6)	58
Other	82	(22)	60
Total	**$ 1,859**	**$ (618)**	**$ 1,241**

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	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2013:			
Capitalized software costs	$ 1,260	$ (475)	$ 785
Long-term debt issuance costs	230	(31)	199
Trade names	81	0	81
Contracts	64	(2)	62
Other	80	(15)	65
Total	**$ 1,715**	**$ (523)**	**$ 1,192**

Estimated future amortization of intangibles with finite useful lives as of June 30, 2014 is as follows:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Amortization of intangible assets	$ 1,151	$ 128	$ 241	$ 188	$ 128	$ 124	$ 342

NOTE 2. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

The principal components of accounts receivable are shown in the table below:

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	June 30, 2014	December 31, 2013
Continuing operations:		
Patient accounts receivable	$ 2,949	$ 2,537
Allowance for doubtful accounts	(753)	(589)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	90	91
Net cost reports and settlements payable and valuation allowances	(118)	(77)
	2,168	1,962
Discontinued operations	3	3
Accounts receivable, net	**$ 2,171**	**$ 1,965**

As of June 30, 2014 and December 31, 2013, our allowance for doubtful accounts was 25.5% and 23.2%, respectively, of our patient accounts receivable. The increase in the provision for doubtful accounts primarily related to a decrease in our self-pay collection rate, as well as higher patient co-pays and deductibles, partially offset by decreased uninsured patient revenues, in the six months ended June 30, 2014. Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. As of June 30, 2014 and December 31, 2013, our allowance for doubtful accounts for self-pay was 76.5% and 75.9%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. As of June 30, 2014 and December 31, 2013, our allowance for doubtful accounts for managed care was 5.7% and 5.6%, respectively, of our managed care patient accounts receivable.

The estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the three months ended June 30, 2014 and 2013 were approximately $167 million and $122 million, respectively, and for the six months ended June 30, 2014 and 2013 were approximately $353 million and $226 million, respectively. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the three months ended June 30, 2014 and 2013 were approximately $55 million and $31 million, respectively, and for the six months ended June 30, 2014 and 2013 were approximately $95 million and $63 million, respectively. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the three months ended June 30, 2014 and 2013 were approximately $157 million and $119 million, respectively, and for the six months ended June 30, 2014 and 2013 were approximately $311 million and $186 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels.

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NOTE 3. DISCONTINUED OPERATIONS

Net operating revenues and income (loss) before income taxes reported in discontinued operations are as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net operating revenues	$ 0	$ 0	$ 1	$ 3
Income (loss) before income taxes	(25)	6	(33)	3

Included in loss before income taxes from discontinued operations in the three months ended June 30, 2014 is approximately $18 million of expense recorded in litigation and investigation costs allocable to one of our previously divested hospitals related to a class action lawsuit discussed in Note 10. In the three months ended June 30, 2013, we recognized a $7 million gain in discontinued operations related to the sale of land.

Should we dispose of additional hospitals or other assets in the future, we may incur asset impairment and restructuring charges in future periods.

NOTE 4. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the six months ended June 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $53 million, consisting $9 million of employee severance costs, $18 million of restructuring costs, and $26 million in acquisition-related costs, which include $4 million of transaction costs and $22 million of acquisition integration charges.

During the six months ended June 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $25 million, consisting of $2 million relating to the impairment of property, $7 million of restructuring costs, $5 million of employee severance costs, $1 million of lease termination costs, and $10 million in acquisition-related costs.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

As of June 30, 2014, our continuing operations consisted of two operating segments, our hospital and other operations and our Conifer subsidiary. During the three months ended March 31, 2014, we combined our California region and our Phoenix market to form our Western region. Our hospital and other operations are currently structured as follows:

- Our Central region includes all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the San Antonio and South Texas markets;
- Our Florida region includes all of our hospitals and other operations in Florida;

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- Our Northeast region includes all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region includes all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;
- Our Western region includes all of our hospitals and other operations in Arizona and California;
- Our Detroit market includes all of our hospitals and other operations in the Detroit, Michigan area;
- Our San Antonio market includes all of our hospitals and other operations in the San Antonio, Texas area;
- Our South Texas market includes all of our hospitals and other operations in the Brownsville and Harlingen, Texas areas; and
- Our Resolute Health market includes our hospital and other operations in the New Braunfels, Texas area.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our statement of operations as they are incurred. Our restructuring plans focus on various aspects of operations, including aligning our operations in the most strategic and cost-effective structure. Certain restructuring and acquisition-related costs are based on estimates. Changes in estimates are recognized as they occur.

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NOTE 5. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of June 30, 2014 and December 31, 2013:

	June 30, 2014	December 31, 2013
Senior notes:		
9 7/8%, due 2014	$ 60	$ 60
9 1/4%, due 2015	474	474
5%, due 2019	1,100	0
6 3/4%, due 2020	300	300
8%, due 2020	750	750
8 1/8%, due 2022	2,800	2,800
6 7/8%, due 2031	430	430
Senior secured notes:		
6 1/4%, due 2018	1,041	1,041
4 3/4%, due 2020	500	500
6%, due 2020	1,800	1,800
4 1/2%, due 2021	850	850
4 3/8%, due 2021	1,050	1,050
Credit facility due 2016	0	405
Capital leases and mortgage notes	428	407
Unamortized note discounts and premium	(19)	(28)
Total long-term debt	**11,564**	**10,839**
Less current portion	622	149
Long-term debt, net of current portion	**$ 10,942**	**$ 10,690**

Credit Agreement

We have a senior secured revolving credit facility (as amended, "Credit Agreement") that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement, which has a scheduled maturity date of November 29, 2016, is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. In addition, borrowings under the Credit Agreement are guaranteed by our wholly owned hospital subsidiaries. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 1.00% to 1.50% or the London Interbank Offered Rate plus a margin ranging from 2.00% to 2.50% per annum based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.375% to 0.500% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At June 30, 2014, we had no cash borrowings outstanding under the revolving credit facility; however, we had approximately $6 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $994 million was available for borrowing under the revolving credit facility at June 30, 2014.

Letter of Credit Facility

On March 7, 2014, we entered into a new letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our existing Credit Agreement, which we transferred to the LC Facility (the "Existing Letters of Credit")), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes.

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Drawings under any letter of credit issued under the LC Facility (including the Existing Letters of Credit) that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.875% per annum. An unused commitment fee is payable at an initial rate of 0.50% per annum with a step down to 0.375% per annum based on the secured debt to EBITDA ratio of 3.00 to 1.00. A per annum fee on the aggregate outstanding amount of issued but undrawn letters of credit (including Existing Letters of Credit) will accrue at a rate of 1.875% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At June 30, 2014, we had approximately $133 million of standby letters of credit outstanding under the LC Facility.

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Senior Notes

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, commencing on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 9 1/4% senior notes due 2015 in July 2014. The proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement.

All of our senior notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to our senior secured notes described in our Annual Report, the obligations of our subsidiaries, and any obligations under our Credit Agreement and the LC Facility to the extent of the collateral. Our Annual Report also describes the covenants and conditions, as well as other provisions, including our redemption rights, set forth in the indentures governing our senior notes.

NOTE 6. GUARANTEES

At June 30, 2014, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $94 million. We had a liability of $69 million recorded for these guarantees included in other current liabilities at June 30, 2014.

We have also guaranteed minimum rent revenue to certain landlords who built medical office buildings on or near our hospital campuses. The maximum potential amount of future payments under these guarantees at June 30, 2014 was $4 million. We had a liability of less than $1 million recorded for these guarantees included in other current liabilities at June 30, 2014.

NOTE 7. EMPLOYEE BENEFIT PLANS

At June 30, 2014, approximately 6.0 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, from time to time, we grant (i) options and restricted stock units with different time-based vesting terms, and (ii) performance-based options and restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe.

Our income from continuing operations for the six months ended June 30, 2014 and 2013 includes $26 million and $22 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements.

Stock Options

The following table summarizes stock option activity during the six months ended June 30, 2014:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding as of December 31, 2013	3,308,111	$ 30.79		
Granted	0			
Exercised	(336,789)	34.08		
Forfeited/Expired	(620,719)	47.96		
Outstanding as of June 30, 2014	**2,350,603**	**$ 25.78**	**$ 50**	**3.8 years**
Vested and expected to vest at June 30, 2014	**2,340,428**	**$ 25.73**	**$ 50**	**3.8 years**
Exercisable as of June 30, 2014	**1,932,972**	**$ 24.03**	**$ 44**	**3.5 years**

There were 336,789 stock options exercised during the six months ended June 30, 2014 with a $4 million aggregate intrinsic value, and 875,005 stock options exercised during the same period in 2013 with a $16 million aggregate intrinsic value.

As of June 30, 2014, there were $3 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 1.3 years.

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There were no stock options granted in the six months ended June 30, 2014. In the six months ended June 30, 2013, we granted an aggregate of

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295,639 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. These stock options will all vest on the third anniversary of the grant date, subject to the terms of the Plan, and will expire on the fifth anniversary of the grant date.

The weighted average estimated fair value of stock options we granted in the six months ended June 30, 2013 was $14.46 per share. This fair value was calculated based on the grant date, using a binomial lattice model with the following assumptions:

	Six Months Ended June 30, 2013
Expected volatility	50%
Expected dividend yield	0%
Expected life	3.6 years
Expected forfeiture rate	6%
Risk-free interest rate	0.48%
Early exercise threshold	100% gain
Early exercise rate	50% per year

The expected volatility used in the binomial lattice model incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price on two dates (one in 2010 and one in 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from the output of the binomial lattice model and represents the period of time that the options are expected to be outstanding. This model incorporates an early exercise assumption in the event of a significant increase in stock price. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise timeframes.

The following table summarizes information about our outstanding stock options at June 30, 2014:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	279,719	4.6 years	$ 4.56	279,719	$ 4.56
$4.57 to $25.089	1,010,431	5.4 years	20.89	871,251	20.55
$25.09 to $32.569	453,862	2.1 years	29.38	453,862	29.38
$32.57 to $42.529	595,009	2.1 years	40.87	316,558	42.24
$42.53 to $55.129	11,582	0.7 years	49.17	11,582	49.17
	2,350,603	**3.8 years**	**$ 25.78**	**1,932,972**	**$ 24.03**

Restricted Stock Units

The following table summarizes restricted stock unit activity during the six months ended June 30, 2014:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested as of December 31, 2013	2,707,222	$ 33.34
Granted	1,280,028	44.36
Vested	(884,431)	30.18
Forfeited	(119,020)	33.68
Unvested as of June 30, 2014	**2,983,799**	**$ 38.04**

In the six months ended June 30, 2014, we granted 1,280,028 restricted stock units subject to time-vesting of which 944,590 will vest and be settled ratably over a three-year period from the date of the grant, 52,971 will vest 100% on the fifth anniversary of the grant date and 10,652 will vest 100% on the third anniversary of the grant date. In addition, we granted 271,815 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of a specified one-year performance goal for the year ending December 31, 2014. Provided the goal is achieved, the performance-based restricted stock units will vest ratably over a three-year period from the grant date. If the performance goal is not achieved, the restricted stock units will be forfeited. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 271,815 units granted, depending on our level of achievement with respect to the performance goal.

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In the six months ended June 30, 2013, we granted 804,062 restricted stock units subject to time-vesting, of which 723,929 will vest and be settled ratably over a three-year period from the grant date and 80,133 will vest 100% on the fifth anniversary of the grant date. In addition, we granted 206,058 performance-based restricted stock units to certain of our senior officers. Because the performance goal for the year ended December 31, 2013 was met at the target level, 100% of the performance-based restricted stock units will vest and be settled ratably over a three-year period from the grant date. We also awarded a grant of 212,180 restricted stock units to our chief executive officer, of which 106,090 are subject to time-vesting and 106,090 are performance-based. If target conditions are met, 50% of this grant will vest three years from the grant date and the remaining 50% will vest six years from the grant date. The award also allows for an additional 106,090 shares to be issued if higher performance criteria are met.

As of June 30, 2014, there were $94 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.6 years.

NOTE 8. EQUITY

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Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the six months ended June 30, 2014 and 2013 (dollars in millions, share amounts in thousands):

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balances at December 31, 2013	96,860	$ 7	$ 4,572	$ (24)	$ (1,422)	$ (2,378)	$ 123	$ 878
Net income (loss)	0	0	0	0	(58)	0	13	(45)
Distributions paid to noncontrolling interests	0	0	0	0	0	0	(18)	(18)
Contributions from noncontrolling interests	0	0	0	0	0	0	3	3
Other comprehensive income	0	0	0	4	0	0	0	4
Purchases of businesses or joint venture interests	0	0	0	0	0	0	29	29
Stock-based compensation expense and issuance of common stock	954	0	22	0	0	0	0	22
Balances at June 30, 2014	97,814	$ 7	$ 4,594	$ (20)	$ (1,480)	$ (2,378)	$ 150	$ 873
Balances at December 31, 2012	104,633	$ 7	$ 4,471	$ (68)	$ (1,288)	$ (1,979)	$ 75	$ 1,218
Net income (loss)	0	0	0	0	(138)	0	8	(130)
Distributions paid to noncontrolling interests	0	0	0	0	0	0	(10)	(10)
Sale of joint venture interest	0	0	53	0	0	0	0	53
Purchases of businesses or joint venture interests	0	0	0	0	0	0	13	13
Repurchase of common stock	(4,453)	0	0	0	0	(192)	0	(192)
Stock-based compensation expense and issuance of common stock	1,558	0	28	0	0	1	0	29
Balances at June 30, 2013	101,738	$ 7	$ 4,552	$ (68)	$ (1,426)	$ (2,170)	$ 86	$ 981

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Changes in Redeemable Noncontrolling Interests in Equity of Consolidated Subsidiaries

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the six months ended June 30, 2014 and 2013:

	Six Months Ended June 30,	
	2014	2013
Balances at beginning of period	$ 247	$ 16
Net income	22	4
Distributions paid to noncontrolling interests	(2)	0
Contributions from noncontrolling interests	10	0
Sales of joint venture interests	0	50
Purchases of businesses	0	10
Balances at end of period	$ 277	$ 80

NOTE 9. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Reserves

At June 30, 2014 and December 31, 2013, the aggregate current and long-term professional and general liability reserves in our accompanying Condensed Consolidated Balance Sheets were approximately $729 million and $699 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.13% and 2.45% at June 30, 2014 and December 31, 2013, respectively.

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period.

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $127 million and $52 million for the six months ended June 30, 2014 and 2013, respectively.

NOTE 10. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the

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loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

Governmental Reviews

Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. Certain of our individual facilities have received inquiries from government agencies, and our facilities may receive such inquiries in future periods. The following material governmental reviews, which have been previously reported, are currently pending.

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- *Kyphoplasty*—From March 2009 through July 2010, seven of our hospitals became the subject of a review by the U.S. Department of Justice ("DOJ") and certain other federal agencies regarding the appropriateness of inpatient treatment for Medicare patients receiving kyphoplasty, which is a surgical procedure used to treat certain spinal conditions. We believe this review is part of a national investigation and is related to a qui tam settlement between the government and the manufacturer and distributor of Kyphon, the product used in performing kyphoplasty procedures. In January 2013, we paid $900,000 to settle claims against one of our hospitals subject to this review, and, in April 2014, we confirmed that another hospital is no longer the subject of investigation. We continue to engage in settlement discussions with the DOJ to resolve this matter with respect to the remaining five hospitals. Although it is impossible to predict the ultimate outcome of those discussions, we believe it is possible that a settlement could be reached in the year ending December 31, 2014. Furthermore, based on current discussions, we believe the amount of the reserve management has established for this matter, as described below, continues to reflect our current estimate of probable liability.

- *Implantable Cardioverter Defibrillators ("ICDs")*—At this time, 56 of our hospitals are part of a nationwide investigation to determine whether ICD procedures from 2002 to 2010 complied with Medicare coverage requirements. In August 2012, the DOJ released its "Medical Review Guidelines/Resolution Model," which sets out, for purposes of this investigation, the patient conditions and criteria for the medical necessity of the implantation of ICDs in Medicare beneficiaries and how the DOJ will enforce the repayment obligations of hospitals. Management has established a reserve, as described below, to reflect the current estimate of probable liability for all of the hospitals under review as part of the government's examination, which commenced in March 2010. We are engaged in potential settlement discussions with the DOJ to resolve this matter, but it is impossible at this time to predict the outcome of those discussions or the amount of any potential resolution.

- *Clinica de la Mama Investigations and Qui Tam Action*—As previously reported, we received a subpoena in May 2012 from the Office of Inspector General ("OIG") of U.S. Department of Health and Human Services in Atlanta seeking documents from January 2004 through May 2012 related to the relationship that certain of our Georgia and South Carolina hospitals had with Hispanic Medical Management, Inc. ("HMM"). HMM was an unaffiliated entity that owned and operated clinics that provided, among other things, prenatal care predominantly to uninsured patients. The hospitals contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. The civil investigation is being conducted by the Civil Division of the DOJ, the U.S. Attorney's Office for the Middle District of Georgia and the Georgia Attorney General's Office, while the parallel criminal investigation is being conducted by the Criminal Division of the DOJ and the U.S. Attorney's Office for the Northern District of Georgia.

  The investigations arose out of a qui tam action captioned *United States of America, ex. rel. Ralph D. Williams v. Health Management Associates, Inc., et al.* filed in the U.S. District Court for the Middle District of Georgia. Tenet and four of its hospital subsidiaries are defendants in the qui tam action, which alleges that the arrangements the hospitals had with HMM violated the federal and state anti-kickback statutes and false claims acts. Both the Georgia Attorney General's Office, on behalf of the State of Georgia, and the U.S. Attorney's Office, on behalf of the United States, have intervened in the qui tam action. We submitted answers to the complaints filed by the relator, the State of Georgia and the United States on July 15, 2014 following the court's denial of our motions to dismiss in June 2014. On July 25, 2014, the civil court granted the United States' unopposed motion to stay discovery in the case.

  If we or our subsidiaries were determined to have violated the anti-kickback statutes, the government could require us to reimburse related government program payments received during the subject period, assess civil monetary penalties including treble damages, exclude individuals or subsidiaries from participation in federal healthcare programs, or seek criminal sanctions against current or former employees of our hospital subsidiary companies or the hospital companies themselves. In a Bill of Information filed on July 23, 2014 with the U.S. District Court for the Northern District of Georgia, Atlanta Division, the U.S. Attorney for that District asserted charges of one count of criminal conspiracy against a former owner of HMM (a non-employee of Tenet) related to the agreements between HMM and the Tenet hospitals described above. In a separate Bill of Information also filed with the court on July 23, 2014, the U.S. Attorney asserted charges of one count of criminal conspiracy against a former employee of a Tenet hospital, but such charges relate to an unaffiliated entity. Management has established a reserve, as described below, to reflect the current estimate of probable liability for these matters, but it is impossible at this time to predict the amount and terms of any potential resolution. We will continue to vigorously defend against the government's allegations.

Except with respect to the matter settled in January 2013 involving one hospital, as discussed above, our analysis of each of these pending reviews is still ongoing, and we are unable to predict with any certainty the progress or final outcome of any discussions with government agencies at this time. Based on currently available information, we increased our reserves by approximately $10 million in the three months ended June 30, 2014, resulting in recorded reserves of approximately $38 million in the aggregate for our potential reimbursement obligations with respect to all of the hospitals under review for their billing practices for kyphoplasty and cardiac defibrillator implantation procedures, as well as the Clinica de la Mama matters. Changes in the reserves may be required in the future as additional information becomes available. We cannot predict the ultimate resolution of any governmental review, and the final amounts paid in settlement or otherwise, if any, could differ materially from our currently recorded reserves.

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Ordinary Course Matters

We are also subject to other claims and lawsuits arising in the ordinary course of business, including potential claims related to, among other things, the care and treatment provided at our hospitals and outpatient facilities, the application of various federal and state labor laws, tax audits and other matters. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material effect on our business, financial condition or results of operations.

In addition, in June 2014, we agreed on principal terms to settle a previously disclosed class action lawsuit captioned *Doe, et al. v. Jo Ellen Smith Medical Foundation*, which was filed in the Civil District Court for the Parish of Orleans in Louisiana in March 1997. The plaintiffs pursued a claim for tortious invasion of privacy due to the fact that in April 1996 patient identifying records from a psychiatric hospital we closed in 1995 were temporarily placed in an unsecure location while the hospital was undergoing renovations. The court certified a class of over 5,000 persons; however, only eight individuals (in addition to the two plaintiffs) have been identified to date in the class certification process. The plaintiffs have asserted each member of the class is entitled to common damages under a theory of presumed "common damage" regardless of whether or not any members of the class were actually harmed or even aware of the incident. In an effort to avoid protracted litigation, the parties settled this matter in June 2014 for a maximum potential payment of $32.5 million, subject to the number and type of claims asserted by the class members. The settlement, which will be funded in amounts and on a schedule to be agreed to by the parties, is subject to execution of a final agreement and court approval. In the three months ended June 30, 2014, we established a reserve of $17 million, recorded in discontinued operations, to reflect our current estimate of probable liability for this matter based on anticipated levels of class member participation.

New claims or inquiries may be initiated against us from time to time. These matters could (1) require us to pay substantial damages or amounts in judgments or settlements, which individually or in the aggregate could exceed amounts, if any, that may be recovered under our insurance policies where coverage applies and is available, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) cause us to close or sell hospitals or otherwise modify the way we conduct business.

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the six months ended June 30, 2014 and 2013:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Other	Balances at End of Period
Six Months Ended June 30, 2014					
Continuing operations	$ 40	$ 15	$ (6)	$ (3)	$ 46
Discontinued operations	6	18	(6)	0	18
	$ 46	**$ 33**	**$ (12)**	**$ (3)**	**$ 64**
Six Months Ended June 30, 2013					
Continuing operations	$ 5	$ 2	$ (2)	$ 0	$ 5
Discontinued operations	5	0	(1)	0	4
	$ 10	**$ 2**	**$ (3)**	**$ 0**	**$ 9**

For the six months ended June 30, 2014 and 2013, we recorded costs of $33 million and $2 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

NOTE 11. INCOME TAXES

During the six months ended June 30, 2014, we recorded income tax expense of $7 million, which includes $3 million to increase our valuation allowance for deferred tax assets. The increase in the valuation allowance relates to an estimated decrease in the future utilization of state net operating loss carryovers.

During the six months ended June 30, 2014, there were no adjustments to our estimated liabilities for uncertain tax positions. The total amount of unrecognized tax benefits as of June 30, 2014 was $43 million, of which $34 million, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. Total accrued interest and penalties on unrecognized tax benefits as of June 30, 2014 were $5 million, all of which related to continuing operations.

As of June 30, 2014, approximately $1 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

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NOTE 12. EARNINGS (LOSS) PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted loss per common share calculations for net loss from continuing operations for the three and six months ended June 30, 2014 and 2013. Net loss is expressed in millions and weighted average shares are expressed in thousands.

	Net Loss (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended June 30, 2014			

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Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (10)	97,677	$ (0.11)
Effect of dilutive stock options and restricted stock units	0	0	0.00
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (10)**	**97,677**	**$ (0.11)**
Three Months Ended June 30, 2013			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (53)	103,010	$ (0.52)
Effect of dilutive stock options and restricted stock units	0	0	0.00
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (53)**	**103,010**	**$ (0.52)**
Six Months Ended June 30, 2014			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (37)	97,419	$ (0.38)
Effect of dilutive stock options and restricted stock units	0	0	0.00
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (37)**	**97,419**	**$ (0.38)**
Six Months Ended June 30, 2013			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (139)	103,557	$ (1.34)
Effect of dilutive stock options and restricted stock units	0	0	0.00
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (139)**	**103,557**	**$ (1.34)**

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three and six months ended June 30, 2014 and 2013 because we did not report income from continuing operations available to shareholders in those periods. In circumstances where we do not have income from continuing operations available to shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations available to shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to shareholders in those periods, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 2,123 and 2,053 for the three and six months ended June 30, 2014, respectively, and 2,326 and 2,282 for the three and six months ended June 30, 2013, respectively.

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NOTE 13. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of June 30, 2014 and December 31, 2013. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

Investments:	June 30, 2014	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable securities — current	$ 2	$ 2	$ 0	$ 0
Investments in Reserve Yield Plus Fund	2	0	2	0
Marketable debt securities — noncurrent	66	27	38	1
	$ 70	**$ 29**	**$ 40**	**$ 1**

Investments:	December 31, 2013	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable securities — current	$ 1	$ 1	$ 0	$ 0
Investments in Reserve Yield Plus Fund	2	0	2	0
Marketable debt securities — noncurrent	62	23	38	1
	$ 65	**$ 24**	**$ 40**	**$ 1**

The fair value of our long-term debt is based on quoted market prices (Level 1). At June 30, 2014 and December 31, 2013, the estimated fair value of our long-term debt was approximately 107.6% and 103.5%, respectively, of the carrying value of the debt.

NOTE 14. ACQUISITIONS

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During the six months ended June 30, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas. We also acquired three ambulatory surgery centers, three urgent care centers, one diagnostic imaging center and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions (the "purchase price") was $42 million.

We are required to allocate the purchase prices of the acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment primarily for several recent acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed. During the six months ended June 30, 2014, we made adjustments to purchase price allocations for businesses acquired in 2013 that increased goodwill by approximately $87 million due to additional information received during the period.

Preliminary purchase price allocations for the acquisitions made during the six months ended June 30, 2014 are as follows:

Current assets	$ 14
Property and equipment	19
Goodwill	71
Current liabilities	(16)
Long-term liabilities	(17)
Noncontrolling interests	(29)
Net cash paid	**$ 42**

The goodwill generated from these transactions, a significant portion of which will not be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and increased reimbursement.

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Approximately $4 million in transaction costs related to prospective and closed acquisitions were expensed during the six months ended June 30, 2014, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statement of Operations.

Pro Forma Information - Unaudited

The following table provides certain pro forma financial information for Tenet as if the Vanguard acquisition had occurred at the beginning of the year ended December 31, 2013.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net operating revenues	**$ 4,042**	**$ 3,940**	**$ 7,968**	**$ 7,826**
Income (loss) from continuing operations, before income taxes	**$ 17**	**$ (66)**	**$ 5**	**$ (198)**

NOTE 15. SEGMENT INFORMATION

Our core business is hospital operations and other, which is focused on owning and operating acute care hospitals and outpatient facilities. We also own various related healthcare businesses. At June 30, 2014, our subsidiaries operated 79 hospitals, with a total of 20,553 licensed beds, primarily serving urban and suburban communities, as well as 189 outpatient centers and six health plans.

We operate revenue cycle management and patient communications and engagement services businesses under our Conifer subsidiary. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. At June 30, 2014, Conifer provided services to more than 700 Tenet and non-Tenet hospital and other clients nationwide. Conifer's two largest customers, Tenet and Catholic Health Initiatives, together comprised 82% and 79% of Conifer's net operating revenues for the six months ended June 30, 2014 and 2013, respectively.

The following table includes amounts for each of our reportable segments and the reconciling items necessary to agree to amounts reported in the accompanying Condensed Consolidated Balance Sheets and Condensed Consolidated Statements of Operations:

	June 30, 2014	December 31, 2013
Assets:		
Hospital operations and other	$ 16,577	$ 15,874
Conifer	330	256
Total	**$ 16,907**	**$ 16,130**

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Capital expenditures:				
Hospital operations and other	$ 237	$ 117	$ 510	$ 248
Conifer	5	6	13	8
Total	**$ 242**	**$ 123**	**$ 523**	**$ 256**

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Net operating revenues:				
Hospital operations and other	$ 3,895	$ 2,297	$ 7,676	$ 4,565
Conifer				
Tenet	138	94	278	186
Other customers	147	125	292	244
	4,180	2,516	8,246	4,995
Intercompany eliminations	(138)	(94)	(278)	(186)
Total	**$ 4,042**	**$ 2,422**	**$ 7,968**	**$ 4,809**

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	Three Months Ended June 30,		Six Months Ended June 30,	
Adjusted EBITDA:				
Hospital operations and other	$ 416	$ 308	$ 755	$ 550
Conifer	44	28	92	60
Total	**$ 460**	**$ 336**	**$ 847**	**$ 610**
Depreciation and amortization:				
Hospital operations and other	$ 204	$ 115	$ 392	$ 225
Conifer	5	6	10	10
Total	**$ 209**	**$ 121**	**$ 402**	**$ 235**
Adjusted EBITDA	**$ 460**	**$ 336**	**$ 847**	**$ 610**
Depreciation and amortization	(209)	(121)	(402)	(235)
Impairment and restructuring charges, and acquisition-related costs	(32)	(11)	(53)	(25)
Litigation and investigation costs	(12)	(2)	(15)	(2)
Interest expense	(190)	(98)	(372)	(201)
Loss from early extinguishment of debt	0	(171)	0	(348)
Investment earnings	0	1	0	1
Income (loss) from continuing operations before income taxes	**$ 17**	**$ (66)**	**$ 5**	**$ (200)**

NOTE 16. RECENTLY ISSUED ACCOUNTING STANDARDS

In April 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-08, "Presentation of Financial Statements (Topic 205) and Property, Plant, and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-08"). ASU 2014-08 changes the requirements for reporting discontinued operations in FASB Accounting Standards Codification Subtopic 205-20, such that a disposal of a component of an entity or a group of components of an entity is required to be reported in discontinued operations if the disposal represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. ASU 2014-08 requires an entity to present, for each comparative period, the assets and liabilities of a disposal group that includes a discontinued operation separately in the asset and liability sections, respectively, of the statement of financial position, as well as additional disclosures about discontinued operations. Additionally, ASU 2014-08 requires disclosures about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements and expands the disclosures about an entity's significant continuing involvement with a discontinued operation. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2015.

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2017.

NOTE 17. SUBSEQUENT EVENTS

In July 2014, we used the net proceeds from the sale of our 5% senior notes due 2019 to redeem approximately $474 million aggregate principal amount outstanding of our 9 1/4% senior notes due 2015. In connection with the redemption, we will record a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the purchase price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs.

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ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is hospital operations and other, which is focused on owning and operating

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acute care hospitals and outpatient facilities. We also operate revenue cycle management, patient communications and engagement services and management services businesses under our Conifer Health Solutions, LLC ("Conifer") subsidiary, which is a separate reportable business segment. MD&A, which should be read in conjunction with the accompanying Condensed Consolidated Financial Statements, includes the following sections:

- Management Overview
- Forward-Looking Statements
- Sources of Revenue
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted patient admission, per patient day, per adjusted patient day and per visit amounts). Continuing operations information includes the results of (i) our same-hospital operations, as described below, (ii) Vanguard Health Systems, Inc. ("Vanguard") and its consolidated subsidiaries, which we acquired effective October 1, 2013, but only for the three and six months ended June 30, 2014, and (iii) Resolute Health Hospital, a newly constructed facility, and Texas Regional Medical Center at Sunnyvale, in which we recently acquired a majority interest, in each case as described below, but only for the three months ended June 30, 2014. Continuing operations information excludes the results of our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. Same-hospital information includes the results of our operations for all periods presented, including the same 49 hospitals operated during the three and six months ended June 30, 2014 and 2013, but excludes the results of (i) legacy Vanguard operations (ii) Resolute Health Hospital and Texas Regional Medical Center, and (iii) our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Hospital Acquisition Completed. On August 1, 2014, we completed our previously announced acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. Emanuel Medical Center is a comprehensive community hospital with services that include emergency, critical care, labor and delivery, pediatrics, cardiology and surgery.

Newly Constructed Hospital Opened. On June 24, 2014, we opened the newly constructed Resolute Health Hospital in New Braunfels, Texas, which is located northeast of San Antonio. The 365,000 square-foot hospital has 128 beds in all-private rooms, as well as an emergency department, and offers a broad range of specialty care, including cardiovascular, orthopedics, oncology, imaging, wound care, rehabilitation, obstetrics and level III neonatal intensive care. Resolute Health's 56-acre wellness campus is designed to draw community members for needs beyond acute healthcare, with services such as a fitness center, health-oriented restaurants, walking trails and an integrative medicine center, which provides complementary therapies such as nutrition counseling, fitness instruction and lifestyle coaching.

Majority Interest in Hospital Acquired. On June 3, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas. Open since 2009, Texas Regional Medical Center is a comprehensive community hospital with services that include a cardiovascular center, spine program, obstetrics program and neonatal intensive care unit, surgical weight loss program and an emergency department. Physician owners continue to retain a minority interest in the hospital.

National Brand of Urgent Care Centers Launched. On May 19, 2014, we launched a new national brand for our existing and future urgent care centers called MedPost Urgent Care. There are currently 23 MedPost Urgent Care centers operating in Arizona, California, Florida, Georgia, Mississippi, Missouri, Tennessee and Texas. These centers are part of a growing national network of walk-in urgent care facilities that are open seven days a week, with extended hours, to care for residents in their communities.

Joint Venture Announced. On May 6, 2014, we announced a joint venture with Texas Tech University Health Sciences Center at El Paso ("TTUHSC") to develop a new teaching hospital for TTUHSC's Paul L. Foster School of Medicine, as well as an 110,000 square foot medical office building in west El Paso, Texas. The new hospital is expected to have up to 140 beds and will operate as a part of the Sierra Providence Health Network, our system of hospitals and outpatient centers in El Paso. Construction on the new teaching hospital is scheduled to begin in 2014 and is expected to be completed in the fall of 2016.

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STRATEGIES AND TRENDS

We are committed to providing the communities our hospitals, outpatient centers and other healthcare facilities serve with high quality, cost-effective healthcare while growing our business, increasing our profitability and creating long-term value for our shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed below.

Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to healthcare providers through Conifer. With respect to our hospitals and outpatient business, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology to remain competitive, to recruit and retain physicians, to increase the number of outpatient centers we own, and to negotiate favorable contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, our management services offerings have expanded to support value-based performance through clinical integration, financial risk management and population health management.

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Commitment to Quality—We have made significant investments in the last decade in equipment, technology, education and operational strategies designed to improve clinical quality at our hospitals and outpatient centers. As a result of our efforts, our Hospital Compare Core Measures scores from the Centers for Medicare and Medicaid Services ("CMS") have consistently exceeded the national average since the end of 2005, and major national private payers have also recognized our achievements relative to quality. These designations are expected to become increasingly important as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others. Through our *Commitment to Quality* and *Performance Excellence Program* initiatives, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effect of reducing costs, increasing payments from Medicare and certain managed care payers for our services, and increasing physician and patient satisfaction, which may improve our volumes.

Development Strategies—We remain focused on opportunities to increase our hospital and outpatient revenues through organic growth and acquisitions, and to expand our Conifer services business.

From time to time, we build new facilities, make strategic acquisitions of healthcare assets and companies, and enter into joint venture arrangements or affiliations with healthcare businesses — in each case in markets where we believe our operating strategies can improve performance and create shareholder value. Most recently, as described in greater detail above, we purchased Emanuel Medical Center, a 209-bed hospital located in Northern California, we opened a newly constructed 128-bed hospital and wellness campus in New Braunfels, Texas, and we acquired a majority interest in a 70-bed regional medical center in a suburban community east of Dallas. In addition, in May 2014, we announced a joint venture with Texas Tech University Health Sciences Center at El Paso to develop and build a new 140-bed teaching hospital and a medical office building in west El Paso, Texas. In the six months ended June 30, 2014, we also acquired three ambulatory surgery centers, three urgent care centers, one diagnostic imaging center and various physician practice entities.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the six months ended June 30, 2014, we derived approximately 37% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. We believe that growth by strategic acquisitions, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. In addition, we expect that our new national MedPost brand will assist us in growing our urgent care business as part of our broader strategy to offer more services to patients and to expand into faster-growing, less capital intensive, higher-margin businesses. Furthermore, we continually evaluate collaboration opportunities with outpatient facilities, healthcare providers, physician groups and others in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality service across the care continuum.

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We intend to continue expanding Conifer's revenue cycle management, patient communications and engagement services, and management services businesses by marketing these services to non-Tenet hospitals and other healthcare-related entities. Conifer provides services to more than 700 Tenet and non-Tenet hospital and other clients nationwide. We believe this business has the potential over time to generate high margins and improve our results of operations. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals, clients for these services include health plans, self-insured employees and other entities.

Realizing HIT Incentive Payments and Other Benefits—Beginning in the year ended December 31, 2011, we achieved compliance with certain of the health information technology ("HIT") requirements under the American Recovery and Reinvestment Act of 2009 ("ARRA"). In 2013, we recognized approximately $96 million of Medicare electronic health record ("EHR") and Medicaid ARRA HIT incentives. During the six months ended June 30, 2014, we recognized approximately $67 million of Medicare and Medicaid EHR ARRA incentives. These incentives partially offset the operating expenses and capital costs we have incurred and continue to incur to invest in HIT systems. We expect to recognize additional incentives in the future. Furthermore, we believe that the operational benefits of HIT, including improved clinical outcomes and increased operating efficiencies, will contribute to our long-term ability to grow our business.

General Economic Conditions—We believe that high unemployment rates in some of the markets our hospitals serve and other adverse economic conditions are continuing to have a negative impact on our bad debt expense levels and payer mix. However, as the economy recovers, we expect to experience improvements in these metrics relative to current levels. In the six months ended June 30, 2014, we believe our volumes were positively impacted by incremental market share as a result of improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. Increases in patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher patient co-pays and deductibles, and demographic trends. We continue to pursue integrated contracting models that maximize our system-wide skills and capabilities in conjunction with our strong market positions to accommodate new payment models. In several markets, we have formed clinical integration organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Most recently, in January 2014, our Abrazo Health network of hospitals in the Phoenix, Arizona area entered into a joint venture with Dignity Health to fund and expand the Arizona Care Network, a physician-led, physician-governed ACO and clinically integrated network focused on improved quality through shared resources, advanced technology and clinical best practices that align with emerging models of care delivery. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of Affordable Care Act—We anticipate that we will benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") that have begun to extend insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by

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governmental payers, we have begun to receive reimbursement for caring for previously uninsured and underinsured patients in 2014. Through collaborative efforts with local community organizations, we have launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans. Effective January 1, 2014, four of the states in which we operate (Arizona, California, Illinois and Massachusetts) expanded their Medicaid programs under the ACA. A fifth state (Michigan) expanded its Medicaid program effective April 1, 2014.

Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is critical that we continue to make steady and measurable progress in 2014 in successfully integrating Vanguard's business and operations into our business processes. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

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RESULTS OF OPERATIONS—OVERVIEW

Selected Operating Statistics for All Continuing Operations Hospitals—The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, and Resolute Health Hospital, which we opened on June 24, 2014, in each case only for the period of time from such acquisition or opening to June 30, 2014. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase to the scale of our operations as a result of our acquisition activity.

	Total Hospital Continuing Operations Three Months Ended June 30,		
	2014	2013	Increase (Decrease)
Total admissions	194,641	120,722	61.2%
Adjusted patient admissions[1]	337,509	195,440	72.7%
Paying admissions (excludes charity and uninsured)	183,714	111,891	64.2%
Charity and uninsured admissions	10,927	8,831	23.7%
Admissions through emergency department	122,086	75,608	61.5%
Emergency department visits	702,009	399,702	75.6%
Total emergency department admissions and visits	824,095	475,310	73.4%
Surgeries — inpatient	53,271	34,340	55.1%
Surgeries — outpatient	120,393	74,329	62.0%
Total surgeries	173,664	108,669	59.8%
Patient days — total	907,093	567,390	59.9%
Adjusted patient days[1]	1,563,681	909,720	71.9%
Average length of stay (days)	4.66	4.70	(0.9)%
Average licensed beds	20,370	13,180	54.6%
Utilization of licensed beds[2]	48.9%	47.3%	1.6%[3]
Total visits	2,066,051	1,072,712	92.6%
Paying visits (excludes charity and uninsured)	1,896,285	958,379	97.9%
Charity and uninsured visits	169,766	114,333	48.5%
Net inpatient revenues	$ 2,393	$ 1,542	55.2%
Net outpatient revenues	$ 1,448	$ 844	71.6%
Net inpatient revenue per admission	$ 12,294	$ 12,773	(3.8)%
Net inpatient revenue per patient day	$ 2,638	$ 2,718	(2.9)%
Net outpatient revenue per visit	$ 701	$ 787	(10.9)%
Net patient revenue per adjusted patient admission[1]	$ 11,380	$ 12,208	(6.8)%
Net patient revenue per adjusted patient day[1]	$ 2,456	$ 2,623	(6.4)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(2) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

(3) The change is the difference between the amounts shown for the three months ended June 30, 2014 compared to the three months ended June 30, 2013.

Operating Statistics on a Same-Hospital Basis—Our results of operations have been and continue to be influenced by industry-wide and company-specific challenges, including constrained volume growth and high levels of bad debt, that have affected our revenue growth and operating expenses. We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended June 30, 2014 and 2013 on a same-hospital basis, where noted, excluding the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, and Resolute Health Hospital, which we opened on June 24, 2014.

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	Same-Hospital Continuing Operations Three Months Ended June 30,

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Admissions, Patient Days and Surgeries	2014	2013	Increase (Decrease)
Total admissions	124,720	120,722	3.3%
Adjusted patient admissions[1]	204,637	195,440	4.7%
Paying admissions (excludes charity and uninsured)	116,801	111,891	4.4%
Charity and uninsured admissions	7,919	8,831	(10.3)%
Admissions through emergency department	80,529	75,608	6.5%
Paying admissions as a percentage of total admissions	93.7%	92.7%	1.0%[2]
Charity and uninsured admissions as a percentage of total admissions	6.3%	7.3%	(1.0)%[2]
Emergency department admissions as a percentage of total admissions	64.6%	62.6%	2.0%[2]
Surgeries — inpatient	34,369	34,340	0.1%
Surgeries — outpatient	89,783	74,329	20.8%
Total surgeries	124,152	108,669	14.2%
Patient days — total	584,251	567,390	3.0%
Adjusted patient days[1]	948,144	909,720	4.2%
Average length of stay (days)	4.68	4.70	(0.4)%
Number of acute care hospitals (at end of period)	49	49	—
Licensed beds (at end of period)	13,231	13,180	0.4%
Average licensed beds	13,196	13,180	0.1%
Utilization of licensed beds[3]	48.7%	47.3%	1.4%[2]

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the amounts shown for the three months ended June 30, 2014 compared to the three months ended June 30, 2013.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Total same-hospital admissions increased by 3,998, or 3.3%, in the three months ended June 30, 2014 compared to the three months ended June 30, 2013. Total surgeries increased by 14.2% in the three months ended June 30, 2014 compared to the same period in 2013, comprised of a 20.8% increase in outpatient surgeries primarily due to our outpatient development strategies and a 0.1% increase in inpatient surgeries. Our emergency department admissions increased 6.5% in the three months ended June 30, 2014 compared to the same period in the prior year. We believe our volumes were positively impacted by incremental market share as a result of improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy. Charity and uninsured admissions decreased 10.3% in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 primarily due to Medicaid expansion in California and health insurance exchange coverage under the ACA.

	Same-Hospital Continuing Operations Three Months Ended June 30,		
Outpatient Visits	2014	2013	Increase (Decrease)
Total visits	1,140,595	1,072,712	6.3%
Paying visits (excludes charity and uninsured)	1,031,920	958,379	7.7%
Charity and uninsured visits	108,675	114,333	(4.9)%
Emergency department visits	432,858	399,702	8.3%
Surgery visits	89,783	74,329	20.8%
Paying visits as a percentage of total visits	90.5%	89.3%	1.2%[1]
Charity and uninsured visits as a percentage of total visits	9.5%	10.7%	(1.2)%[1]

(1) The change is the difference between the amounts shown for the three months ended June 30, 2014 compared to the three months ended June 30, 2013.

Total same-hospital outpatient visits increased 67,883, or 6.3%, in the three months ended June 30, 2014 compared to the three months ended June 30, 2013, which included 7.7% growth for paying visits. Approximately 69% of the growth in outpatient visits was organic.

Outpatient surgery visits increased by 20.8% in the three months ended June 30, 2014 compared to the same period in 2013. Charity and uninsured outpatient visits decreased by 4.9% in the three months ended June 30, 2014 compared to the three months ended June 30, 2013.

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	Same-Hospital Continuing Operations Three Months Ended June 30,		
Revenues	2014	2013	Increase (Decrease)
Net operating revenues	$ 2,578	$ 2,422	6.4%
Revenues from the uninsured	$ 147	$ 170	(13.5)%
Net inpatient revenues[1]	$ 1,540	$ 1,542	(0.1)%
Net outpatient revenues[1]	$ 927	$ 844	9.8%

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $52 million and $69 million for the three months ended June 30, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of

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$95 million and $101 million for the three months ended June 30, 2014 and 2013, respectively.

Net operating revenues increased by $156 million, or 6.4%, on a same-hospital basis in the three months ended June 30, 2014 compared to the same period in 2013, primarily due to increases in inpatient and outpatient volumes, improved managed care pricing, and increased revenues from services provided by our Conifer subsidiary to third parties. Revenues from the uninsured decreased 13.5% in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 primarily due to Medicaid expansion in California and health insurance exchange coverage under the ACA. Net operating revenues in the three months ended June 30, 2014 included $51 million of Medicaid disproportionate share hospital ("DSH") and other state-funded subsidy revenues compared to $119 million in the same period in 2013 on a same-hospital basis. During the three months ended June 30, 2013, we recognized $66 million of net revenues related to the California provider fee program; we did not recognize any revenues related to this program during the three months ended June 30, 2014 because the current program has not been approved by CMS yet. Net patient revenues increased by 3.4% in the three months ended June 30, 2014 compared to the same period in 2013.

	Same-Hospital Continuing Operations Three Months Ended June 30,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 12,348	$ 12,773	(3.3)%
Net inpatient revenue per patient day	$ 2,636	$ 2,718	(3.0)%
Net outpatient revenue per visit	$ 813	$ 787	3.3%
Net patient revenue per adjusted patient admission[1]	$ 12,055	$ 12,208	(1.3)%
Net patient revenue per adjusted patient day[1]	$ 2,602	$ 2,623	(0.8)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Net inpatient revenue per admission decreased 3.3% in the three months ended June 30, 2014 compared to the same period in 2013. The decrease is primarily due to the $66 million of net revenues related to the California provider fee program that were recognized during the three months ended June 30, 2013 compared to no revenues under this program in the 2014 period. The 3.3% increase in net outpatient revenue per visit was primarily due to the improved terms of our managed care contracts.

	Same-Hospital Continuing Operations Three Months Ended June 30,		
Provision for Doubtful Accounts	2014	2013	Increase (Decrease)
Provision for doubtful accounts	$ 209	$ 207	1.0%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.5%	7.9%	(0.4)%[1]
Collection rate on self-pay accounts[2]	27.8%	28.7%	(0.9)%[1]
Collection rate on commercial managed care accounts	98.3%	98.2%	0.1%[1]

(1) The change is the difference between the amounts shown for the three months ended June 30, 2014 compared to the three months ended June 30, 2013.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

Provision for doubtful accounts increased by $2 million, or 1.0%, in the three months ended June 30, 2014 compared to the same period in 2013. The increase in the provision for doubtful accounts primarily related to the 90 basis point decrease in our self-pay collection rate, as well higher patient co-pays and deductibles, partially offset by the decrease in revenues from the uninsured. Our self-pay collection rate, which is the blended collection rate for uninsured and balance after insurance accounts receivable, was approximately 27.8% at June 30, 2014 and 28.7% at June 30, 2013.

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	Same-Hospital Continuing Operations Three Months Ended June 30,		
Selected Operating Expenses	2014	2013	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,103	$ 1,026	7.5%
Supplies	413	387	6.7%
Other operating expenses	601	514	16.9%
Total	$ 2,117	$ 1,927	9.9%
Conifer			
Salaries, wages and benefits	$ 178	$ 140	27.1%
Other operating expenses	63	53	18.9%
Total	$ 241	$ 193	24.9%
Total			
Salaries, wages and benefits	$ 1,281	$ 1,166	9.9%
Supplies	413	387	6.7%
Other operating expenses	664	567	17.1%
Total	$ 2,358	$ 2,120	11.2%
Rent/lease expense[1]			

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Hospital Operations and other	$ 35	$ 39	(10.3)%
Conifer	5	3	66.7%
Total	$ 40	$ 42	(4.8)%
Hospital Operations and other[2]			
Salaries, wages and benefits per adjusted patient day	$ 1,161	$ 1,128	2.9%
Supplies per adjusted patient day	436	425	2.6%
Other operating expenses per adjusted patient day	615	565	8.8%
Total per adjusted patient day	$ 2,212	$ 2,118	4.4%
Salaries, wages and benefits per adjusted patient admission	$ 5,380	$ 5,250	2.5%
Supplies per adjusted patient admission	2,018	1,980	1.9%
Other operating expenses per adjusted patient admission	2,849	2,630	8.3%
Total per adjusted patient admission	$ 10,247	$ 9,860	3.9%

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

Total selected operating expenses, which is defined as salaries, wages and benefits, supplies and other operating expenses, increased by 4.4% and 3.9% on a per adjusted patient day and per adjusted patient admission basis, respectively, in the three months ended June 30, 2014 compared to the three months ended June 30, 2013.

Salaries, wages and benefits per adjusted patient admission increased by approximately 2.5% in the three months ended June 30, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs in the three months ended June 30, 2014 compared to the three months ended June 30, 2013.

Supplies expense per adjusted patient admission increased by 1.9% in the three months ended June 30, 2014 compared to the three months ended June 30, 2013. The change in supplies expense was primarily attributable to higher costs for pharmaceuticals and volume growth in our supply-intensive surgical services.

Other operating expenses per adjusted patient admission increased by 8.3% in the three months ended June 30, 2014 compared to the same period in 2013. This change is primarily due to higher medical fees related to a greater number of employed and contracted physicians, increased costs of contracted services and increased malpractice expense. Malpractice expense in the 2014 period included an unfavorable adjustment of approximately $1 million due to a 17 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $6 million as a result of a 72 basis point increase in the interest rate in the 2013 period.

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Salaries, wages and benefits expense for Conifer increased by $38 million in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Other operating expenses for Conifer increased by $10 million in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 primarily due to higher costs related to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

The table below shows the pre-tax and after-tax impact on continuing operations for the three and six months ended June 30, 2014 and 2013 of the following items:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (32)	$ (11)	$ (53)	$ (25)
Litigation and investigation costs	(12)	(2)	(15)	(2)
Loss from early extinguishment of debt	(0)	(171)	(0)	(348)
Pre-tax impact	$ (44)	$ (184)	$ (68)	$ (375)
Total after-tax impact	$ (27)	$ (122)	$ (42)	$ (242)
Diluted per-share impact of above items	$ (0.28)	$ (1.18)	$ (0.43)	$ (2.31)
Diluted earnings per share, including above items	$ (0.11)	$ (0.52)	$ (0.38)	$ (1.34)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $406 million at June 30, 2014, an increase of $265 million from $141 million at March 31, 2014.

Significant cash flow items in the three months ended June 30, 2014 included:

- Capital expenditures of $242 million;

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- Purchases of businesses for $33 million;
- Interest payments of $255 million;
- $170 million net repayments under our revolving credit facility; and
- $500 million of net proceeds from the issuance of 5% senior notes due 2019.

Net cash provided by operating activities was $247 million in the six months ended June 30, 2014 compared to $128 million in the six months ended June 30, 2013. Key positive and negative factors contributing to the change between the 2014 and 2013 periods include the following:

- Increased income from continuing operations before income taxes of $237 million, excluding loss from early extinguishment of debt, interest expense, investment earnings, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization, in the six months ended June 30, 2014 compared to the six months ended June 30, 2013;
- The favorable impact of a reduction of approximately $44 million in net amounts we are owed under Medicaid supplemental programs in the 2014 period;
- $5 million more cash used in operating activities from discontinued operations;
- Income tax payments of $19 million in the six months ended June 30, 2014 compared to $8 million in the six months ended June 30, 2013;
- An increase of $65 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- Higher interest payments of $134 million.

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FORWARD-LOOKING STATEMENTS

The information in this report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. These forward-looking statements represent management's current belief, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors — many of which we are unable to predict or control — that may cause our actual results, performance or achievements, or healthcare industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the risks described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in our Annual Report and in this report. Should one or more of the risks and uncertainties described in our Annual Report or this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statements. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

All forward-looking statements attributable to us are expressly qualified in their entirety by this cautionary statement.

SOURCES OF REVENUE

We receive revenues for patient services from a variety of sources, primarily managed care payers and the federal Medicare program, as well as state Medicaid programs, indemnity-based health insurance companies and self-pay patients (that is, patients who do not have health insurance and are not covered by some other form of third-party arrangement).

The table below shows the sources of net patient revenues before provision for doubtful accounts for our continuing general hospitals, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Three Months Ended June 30,			Six Months Ended June 30,		
Net Patient Revenues from:	2014	2013	Increase (Decrease)[1]	2014	2013	Increase (Decrease)[1]
Medicare	22.5%	21.0%	1.5%	22.6%	22.0%	0.6%
Medicaid	9.9%	9.9%	—%	8.8%	9.0%	(0.2)%
Managed care	58.0%	58.1%	(0.1)%	57.9%	58.0%	(0.1)%
Indemnity, self-pay and other	9.6%	11.0%	(1.4)%	10.7%	11.0%	(0.3)%

(1) The increase (decrease) is the difference between the 2014 and 2013 percentages shown.

Our payer mix on an admissions basis for our continuing general hospitals, expressed as a percentage of total admissions from all sources, is shown below:

	Three Months Ended June 30,	Six Months Ended June 30,

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Admissions from:	2014	2013	Increase (Decrease)[1]	2014	2013	Increase (Decrease)[1]
Medicare	27.3%	27.9%	(0.6)%	28.1%	28.7%	(0.6)%
Medicaid	11.6%	12.0%	(0.4)%	11.3%	11.9%	(0.6)%
Managed care	53.5%	49.6%	3.9%	52.8%	49.0%	3.8%
Indemnity, self-pay and other	7.6%	10.5%	(2.9)%	7.8%	10.4%	(2.6)%

(1) The increase (decrease) is the difference between the 2014 and 2013 percentages shown.

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GOVERNMENT PROGRAMS

The Medicare program, the nation's largest health insurance program, is administered by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services ("HHS"). Medicare is a health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources, and is jointly funded by the federal government and state governments. Medicaid is the largest source of funding for medical and health-related services for the nation's poor and most vulnerable individuals.

The Affordable Care Act is changing how healthcare services in the United States are covered, delivered and reimbursed. One key provision of the ACA is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. For individuals who are not exempt from the individual mandate, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Recently, two federal appeals court panels issued conflicting rulings on whether the government could subsidize health insurance premiums under the ACA; pending further review of the issue by the courts, the government has stated that it will continue paying the subsidies to insurance companies on behalf of consumers in the 36 states that use the federal exchange. Also beginning in 2014, those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty. The "employer mandate" provision of the ACA requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. In July 2013, the U.S. Treasury Department announced a one-year delay (to January 1, 2015) in the imposition of penalties and the reporting requirements of the employer mandate. On February 10, 2014, the requirements of the employer mandate were further delayed until January 1, 2016. Based on the Congressional Budget Office's most recent estimates, we do not believe that the delays in the employer mandate will have a discernible effect on insurance coverage. Another key provision of the ACA is the expansion of Medicaid coverage. Prior to the passage of the ACA, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The ACA expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. Under the ACA, the federal government will pay 100% of the costs of Medicaid expansion in 2014, 2015 and 2016; federal funding will be reduced to 90% over the course of the four-year period from 2017 through 2020, and it will remain at 90% for 2021 and beyond. The expansion of the Medicaid program in each state will require state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. As of June 30, 2014, 26 states and the District of Columbia have taken action to expand Medicaid and three others are considering action to expand in the near future. We currently operate hospitals in five of the states that are expanding in 2014 and two of the states that are considering expansion. We cannot provide any assurances as to whether or when the other states in which we operate might choose to expand their Medicaid programs. We anticipate that healthcare providers will generally benefit over time from insurance coverage provisions of the ACA; however, the ACA also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including: (1) negative adjustments to the annual market basket updates for Medicare inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and (2) reductions to Medicare and Medicaid DSH payments beginning, with respect to Medicare payments, in federal fiscal year ("FFY") 2014 and, with respect to Medicaid payments, in FFY 2017, as the number of uninsured individuals declines. We are unable to predict the net effect of the ACA on our future revenues and operations at this time due to uncertainty regarding the ultimate number of uninsured patients who will obtain insurance coverage, uncertainty regarding future negotiations with payers, uncertainty regarding Medicaid expansion, and gradual and, in some cases, delayed implementation. Furthermore, we are unable to predict the outcome of legal challenges to certain provisions (including the provisions regarding subsidies) of the ACA, what action, if any, Congress might take with respect to the ACA or the actions individual states might take with respect to expanding Medicaid coverage. For a discussion of the risks and uncertainties associated with the Affordable Care Act, including the future course of related legislation and regulations, see Item 1A, Risk Factors, of Part I of our Annual Report.

The Medicare and Medicaid programs are also subject to statutory and regulatory changes, administrative and judicial rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government healthcare program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

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Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues, including our general hospitals and other operations, for services provided to

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patients enrolled in the Original Medicare Plan for the three and six months ended June 30, 2014 and 2013 are set forth in the following table:

Revenue Descriptions	Three Months Ended June 30, 2014[1]	Three Months Ended June 30, 2013	Six Months Ended June 30, 2014[1]	Six Months Ended June 30, 2013
Medicare severity-adjusted diagnosis-related group — operating	$ 404	$ 264	$ 841	$ 555
Medicare severity-adjusted diagnosis-related group — capital	37	23	77	48
Outliers	16	11	36	25
Outpatient	246	134	476	270
Disproportionate share	95	52	191	106
Direct Graduate and Indirect Medical Education[2]	67	27	131	52
Other[3]	21	(4)	25	13
Adjustments for prior-year cost reports and related valuation allowances	18	15	19	16
Total Medicare net patient revenues	**$ 904**	**$ 522**	**$ 1,796**	**$ 1,085**

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center and Resolute Health Hospital.

(2) Includes Indirect Medical Education revenues earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.

(3) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

A general description of the types of payments we receive for services provided to patients enrolled in the Original Medicare Plan is provided in our Annual Report. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found under "Regulatory and Legislative Changes" below.

Disproportionate Share Hospital Payments

As previously disclosed, the statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates ("FFY 2005 Final Rule"). During the three months ended December 31, 2012, the federal district court in the District of Columbia ruled in *Allina Health Services v. Sebelius* that the Secretary of HHS ("Secretary") failed to follow the Administrative Procedures Act when promulgating the regulation requiring the inclusion of the Medicare Advantage days in the DSH calculation. The court vacated the regulation and remanded the matter to the Secretary to recalculate the DSH reimbursement without using the interpretation set forth in the FFY 2005 Final Rule. The Secretary appealed the district court's decision to the U.S. Court of Appeals for the D.C. Circuit ("Circuit Court"). On April 1, 2014, the Circuit Court: (1) affirmed the district court's order to vacate the regulation; (2) reversed the district court's order regarding the manner in which the reimbursement should be calculated; and (3) remanded the matter to HHS. During the three months ended June 30, 2014, the Secretary announced that HHS would not seek a rehearing at the Circuit Court or petition the U.S. Supreme Court to review the Circuit Court's decision. We are not able to predict what action the Secretary might take with respect to the DSH calculation; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 16.9% and 15.7% of net patient revenues before provision for doubtful accounts at our continuing general hospitals for the six months ended June 30, 2014 and 2013, respectively. We also receive DSH payments under various state Medicaid programs. For the six months ended June 30, 2014 and 2013, our revenues attributable to DSH payments and other state-funded subsidy payments for our continuing operations were approximately $311 million and $186 million, respectively.

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Several states in which we operate continue to face budgetary challenges due to the slow economic recovery and other factors that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

Because we cannot predict what actions the federal government or the states may take under existing legislation and future legislation to address budget gaps, deficits, Medicaid expansion or Medicaid section 1115 waivers, we are unable to assess the effect that any such legislation might have on our business, but the impact on our future financial position, results of operations or cash flows could be material.

Medicaid-related patient revenues recognized by our continuing general hospitals from Medicaid-related programs in the states in which they are located, as well as from Medicaid programs in neighboring states, for the six months ended June 30, 2014 and 2013 are set forth in the table below:

Hospital Location	Six Months Ended June 30, 2014[1] Medicaid	Six Months Ended June 30, 2014[1] Managed Medicaid	Six Months Ended June 30, 2013 Medicaid	Six Months Ended June 30, 2013 Managed Medicaid
Michigan	$ 166	$ 125	$ —	$ —

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Texas	135	110	53	61
Florida	92	36	86	31
California	70	107	136	84
Illinois	44	15	—	—
Georgia	41	17	40	16
Pennsylvania	38	94	36	96
Missouri	32	3	32	3
Massachusetts	17	23	—	—
North Carolina	14	3	16	2
South Carolina	8	16	13	12
Alabama	6	—	7	—
Arizona	6	56	—	—
Tennessee	3	13	5	14
	$ 672	$ 618	$ 424	$ 319

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center and Resolute Health Hospital.

Regulatory and Legislative Changes

Material updates to the information set forth in our Annual Report about the Medicare and Medicaid payment systems are provided below.

Proposed Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year. On April 30, 2014, CMS issued Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2015 Rates ("Proposed IPPS Rule"). The Proposed IPPS Rule includes the following proposed payment and policy changes:

- A market basket increase of 2.7% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of EHR technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology would receive a reduced market basket increase); CMS is also proposing certain adjustments to the estimated 2.7% market basket increase that result in a net market basket update of 1.3% (before budget neutrality adjustments), including:
    - Market basket index and multifactor productivity reductions required by the ACA of 0.2% and 0.4%, respectively; and
    - A documentation and coding recoupment reduction of 0.8% as part of the recoupment required by the American Taxpayer Relief Act of 2012;

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- Updates to the factors used to determine the amount and distribution of Medicare uncompensated care disproportionate share ("UC-DSH") payments;
- Implementation of a 1% payment decrease for hospitals that rank in the top 25% of CMS' measurement of hospital acquired conditions;
- Updates to the Core Based Statistical Areas that affect the wage index used to adjust MS-DRG payments for geographic differences;
- A 0.86% net increase in the capital federal MS-DRG rate; and
- An increase in the cost outlier threshold from $21,748 to $25,799.

CMS projects that the combined impact of the payment and policy changes in the Proposed IPPS Rule will yield an average 0.9% decrease in payments for hospitals in large urban areas (populations over one million). Using the impact percentages in the Proposed IPPS Rule as applied to our IPPS payments for the nine months ended June 30, 2014, the estimated annual impact for all changes in the Proposed IPPS Rule on our hospitals is a decrease in our Medicare inpatient revenues of approximately $21 million, most of which is related to an expected decrease in UC-DSH reimbursement. Because of the uncertainty regarding the proposals and other factors that may influence our future IPPS payments by individual hospital, including admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate.

Payment and Policy Changes to the Medicare Inpatient Psychiatric Facility Prospective Payment System

On July 31, 2014, CMS issued a final rule updating Medicare payment policies and rates for the Medicare inpatient psychiatric facility ("IPF") prospective payment system for FFY 2015 ("IPF-PPS Final Rule"). The IPF-PPS Final Rule includes the following payment and policy change for IPFs:

- A net payment increase for IPFs of 2.1%, which reflects a market basket increase of 2.9% reduced by market basket index and multifactor productivity adjustments required by the ACA of 0.3% and 0.5%, respectively; and
- A decrease in the outlier fixed-dollar loss threshold from $10,245 to $8,755.

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At June 30, 2014, 21 of our general hospitals operated IPF units. CMS projects that the payment changes in the IPF-PPS Final Rule will result in an estimated total increase in aggregate IPF payments of 2.5%, which includes an average 2.7% increase for IPF units in hospitals located in urban areas for FFY 2015. Using the urban IPF unit impact percentage as applied to our Medicare IPF payments for the nine months ended June 30, 2014, the annual impact of the payment and policy changes in the IPF-PPS Final Rule may result in an estimated increase in our Medicare revenues of approximately $1 million. Because of the uncertainty associated with various factors that may influence our future IPF payments, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of these changes.

Payment and Policy Changes to the Medicare Inpatient Rehabilitation Facility Prospective Payment System

On July 31, 2014, CMS issued a final rule updating Medicare payment policies and rates for the Medicare inpatient rehabilitation facility ("IRF") prospective payment system for FFY 2015 ("IRF-PPS Final Rule"). The IRF-PPS Final Rule includes the following payment and policy changes for IRFs:

- A net payment increase for IRFs of 2.2%, which reflects a market basket increase of 2.9% reduced by market basket index and multifactor productivity adjustments required by the ACA of 0.2% and 0.5%, respectively; and
- An additional 0.2% aggregate payment increase due to updated outlier threshold results.

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At June 30, 2014, we operated one freestanding IRF, and 14 of our general hospitals operated IRF units. CMS projects that the payment changes in the IRF-PPS Final Rule will result in an estimated total increase in aggregate IRF payments of 2.4%, which includes an average 2.2% increase for freestanding IRFs, and an average 2.6% increase for IRF units in hospitals located in urban areas for FFY 2015. Using the applicable freestanding and urban IRF unit impact percentages as applied to our Medicare IRF payments for the nine months ended June 30, 2014, the annual impact of the payment and policy changes in the IRF-PPS Final Rule may result in an estimated increase in our Medicare revenues of approximately $1 million. Because of the uncertainty associated with various factors that may influence our future IRF payments, including legislative action, admission volumes, length of stay and case mix, and the impact of compliance with admission criteria, we cannot provide any assurances regarding our estimate of the impact of these changes.

Proposed Payment and Policy Changes to the Medicare Outpatient Prospective Payment System

On July 3, 2014, CMS released the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems proposed changes for calendar year 2015 ("Proposed OPPS Rule"). The Proposed OPPS Rule includes the following proposed payment and policy changes:

- An estimated market basket increase of 2.7%, minus market basket index and multifactor productivity reductions required by the ACA of 0.2% and 0.4%, respectively; and
- An expansion of the items and services that are packaged into the outpatient prospective payment system ("OPPS") payments.

CMS projects that the combined impact of the payment and policy changes in the Proposed OPPS Rule will yield an average 2.2% increase in OPPS payments for all hospitals and an average 2.3% increase in OPPS payments for hospitals in large urban areas (populations over one million). According to CMS' estimates, the projected annual impact of the payment and policy changes in the Proposed OPPS Rule on our hospitals is a $14 million increase in Medicare outpatient revenues. Because of the uncertainty associated with the proposals, and the other factors that may influence our future OPPS payments by individual hospital, including legislative action, patient volumes and case mix, we cannot provide any assurances regarding this estimate.

Proposed Payment and Policy Changes to the Medicare Physician Fee Schedule

On July 3, 2014, CMS released the proposed update to the Medicare Physician Fee Schedule ("MPFS"). The MPFS is the schedule of rates Medicare pays for physician and other professional services and is updated annually. The MPFS update is determined by the "sustainable growth rate" ("SGR") formula in accordance with the Balanced Budget Act of 1997. The Protecting Access to Medicare Act of 2014 ("PAMA"), described below, includes a zero percent update to the 2015 MPFS through March 31, 2015. However, the SGR takes effect on April 1, 2015 unless the Congress intervenes. In March 2014 (prior to the enactment of the PAMA), CMS estimated that the MPFS SGR-based update for CY 2015 would be a reduction of 20.9%. In most prior years, Congress has taken action to avert a large reduction in MPFS rates before it went into effect. These actions have often resulted in payment reductions to other health care providers (including hospitals) to maintain budget neutrality. Although the historical pattern suggests that the Congress will override the SGR formula for the nine months commencing April 1, 2015, we cannot provide any assurances in that regard. In addition, we cannot predict the level or type of payment reductions affecting our hospitals that might be used to offset a temporary override or permanent replacement of the SGR formula.

The Protecting Access to Medicare Act of 2014

On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014. This new law prevented a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on April 1, 2014. The law includes the following provisions:

- An extension of the 0.5% update for services reimbursed under the MPFS that applied from January 1, 2014 through March 31, 2014 for the period April 1, 2014 through December 31, 2014;
- A zero percent update to the 2015 MPFS through March 31, 2015;
- A delay in the implementation of ICD-10 (as discussed in our Annual Report) from October 1, 2014 until at least October 1, 2015 (based on recent CMS announcements, we expect the use of ICD-10 to begin on October 1, 2015);
- An additional one-year delay of the ACA Medicaid DSH reduction to October 1, 2016 (funding of this delay will be achieved by a net increase in the FFY 2017 through 2023 ACA Medicaid DSH reductions);

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- A one-year extension of the ACA Medicaid DSH reduction through FFY 2024;
- A six-month partial extension of the moratorium on enforcement of the "two-midnight rule" (as discussed in our Annual Report) through March 31, 2015; and
- Modification of the FFY 2024 Medicare sequestration consisting of a 4% increase to the sequestration reduction for the first six months of FFY 2024, and then a decrease of the reduction to zero percent for the second six months of that FFY.

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PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service healthcare delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate healthcare can be efficiently delivered in the most cost-effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted healthcare providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted healthcare providers. PPO members who use contracted healthcare providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible healthcare plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient revenues during the six months ended June 30, 2014 and 2013 was $4.4 billion and $2.7 billion, respectively. Approximately 62% of our managed care net patient revenues for the six months ended June 30, 2014 was derived from our top ten managed care payers. National payers generated approximately 47% of our total net managed care revenues. The remainder comes from regional or local payers. At June 30, 2014 and December 31, 2013, approximately 61% and 58%, respectively, of our net accounts receivable related to continuing operations were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of June 30, 2014, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $13 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have had improved year-over-year managed care pricing, we expect some moderation in the pricing percentage increases in future years. It is not clear what impact, if any, the increased obligations on managed care and other payers imposed by the Affordable Care Act will have on our commercial managed care volumes and payment rates. In the six months ended June 30, 2014, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 74% higher than our aggregate yield on a per admission basis from governmental payers, including managed Medicare and Medicaid insurance plans.

Indemnity

An indemnity-based agreement generally requires the insurer to reimburse an insured patient for healthcare expenses after those expenses have been incurred by the patient, subject to policy conditions and exclusions. Unlike an HMO member, a patient with indemnity insurance is free to control his or her utilization of healthcare and selection of healthcare providers.

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SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant portion of our self-pay patients is admitted through our hospitals'

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emergency departments and often requires high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe that our level of self-pay patients has been higher in the last several years than previous periods due to a combination of broad economic factors, including increased unemployment rates, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-pays and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectability problems. At June 30, 2014 and December 31, 2013, approximately 8% and 7%, respectively, of our net accounts receivable related to continuing operations were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have been increasing our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

Over the longer term, several other initiatives we have previously announced should also help address this challenge. For example, our *Compact with Uninsured Patients* ("Compact") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically have been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

Under the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), a new Consumer Financial Protection Bureau ("CFPB") was formed within the U.S. Federal Reserve to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. We believe that the CFPB regulatory and enforcement processes will have a significant impact on Conifer's operations. For additional information, see Item 1, Business — Regulations Affecting Conifer, of Part I of our Annual Report and Item 1, Legal Proceedings, in Part II of this report.

Our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the three months ended June 30, 2014 and 2013 were approximately $167 million and $122 million, respectively, and for the six months ended June 30, 2014 and 2013 were approximately $353 million and $226 million, respectively. (All 2014 amounts in this paragraph include the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center and Resolute Health Hospital.) We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the three months ended June 30, 2014 and 2013 were approximately $157 million and $119 million, respectively, and for the six months ended June 30, 2014 and 2013 were approximately $311 million and $186 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Our estimated costs (based on

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the selected operating expenses described above) of caring for charity care patients for the three months ended June 30, 2014 and 2013 were $55 million and $31 million, respectively, and for the six months ended June 30, 2014 and 2013 were approximately $95 million and $63 million, respectively. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues.

The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, because of the many variables involved, we are unable to predict with certainty the net impact on us of the expected increase in revenues and expected decrease in bad debt expense from providing care to previously uninsured and underinsured individuals, and numerous other provisions in the law that may affect us. In addition, even after implementation of the ACA, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage under the ACA and for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government healthcare insurance program.

RESULTS OF OPERATIONS

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the three and six months ended June 30, 2014 and 2013:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net operating revenues:				
General hospitals	$ 3,859	$ 2,358	$ 7,664	$ 4,735
Other operations	503	271	1,004	488
Net operating revenues before provision for doubtful accounts	4,362	2,629	8,668	5,223
Less provision for doubtful accounts	320	207	700	414
Net operating revenues	**4,042**	**2,422**	**7,968**	**4,809**

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Operating expenses:				
Salaries, wages and benefits	1,956	1,166	3,877	2,327
Supplies	649	387	1,277	771
Other operating expenses, net	1,035	567	2,034	1,135
Electronic health record incentives	(58)	(34)	(67)	(34)
Depreciation and amortization	209	121	402	235
Impairment and restructuring charges, and acquisition-related costs	32	11	53	25
Litigation and investigation costs	12	2	15	2
Operating income	**$ 207**	**$ 202**	**$ 377**	**$ 348**

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net operating revenues	100.0%	100.0%	100.0%	100.0%
Operating expenses:				
Salaries, wages and benefits	48.4%	48.1%	48.7%	48.4%
Supplies	16.1%	16.0%	16.0%	16.0%
Other operating expenses, net	25.5%	23.4%	25.5%	23.6%
Electronic health record incentives	(1.4)%	(1.4)%	(0.8)%	(0.7)%
Depreciation and amortization	5.2%	5.0%	5.0%	4.9%
Impairment and restructuring charges, and acquisition-related costs	0.8%	0.5%	0.7%	0.5%
Litigation and investigation costs	0.3%	0.1%	0.2%	0.1%
Operating income	**5.1%**	**8.3%**	**4.7%**	**7.2%**

Net operating revenues of our general hospitals include inpatient and outpatient revenues, as well as nonpatient revenues (rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) services provided by our Conifer subsidiary to third parties and (4) our health plans recently acquired from Vanguard. Revenues from our general hospitals represented approximately 88% and 90% of our total net operating revenues before provision for doubtful accounts for the three months ended June 30, 2014 and 2013, respectively, and approximately 88% and 91% for the six months ended June 30, 2014 and 2013, respectively.

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Net operating revenues from our other operations were $503 million and $271 million in the three months ended June 30, 2014 and 2013, respectively, and $1.004 billion and $488 million in the six months ended June 30, 2014 and 2013, respectively. The increase in net operating revenues from other operations during 2014 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our recently acquired health plans and additional physician practices. Equity earnings of unconsolidated affiliates included in our net operating revenues from other operations were $4 million and $1 million for the three months ended June 30, 2014 and 2013, respectively, and $5 million and $12 million in the six months ended June 30, 2014 and 2013, respectively. Included in 2013 equity earnings of unconsolidated affiliates is $10 million of earnings associated with stepping up our basis in a previously held investment in an ambulatory surgery center in which we acquired a controlling interest and are now consolidating.

The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, and Resolute Health Hospital, which we opened on June 24, 2014, in each case only for the period of time from such acquisition or opening to June 30, 2014. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase to the scale of our operations as a result of our acquisition activity.

	Total Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total admissions	194,641	120,722	61.2%	388,914	246,651	57.7%
Adjusted patient admissions[1]	337,509	195,440	72.7%	661,319	393,105	68.2%
Paying admissions (excludes charity and uninsured)	183,714	111,891	64.2%	365,457	229,217	59.4%
Charity and uninsured admissions	10,927	8,831	23.7%	23,457	17,434	34.5%
Admissions through emergency department	122,086	75,608	61.5%	244,687	155,816	57.0%
Emergency department visits	702,009	399,702	75.6%	1,367,011	801,780	70.5%
Total emergency department admissions and visits	824,095	475,310	73.4%	1,611,698	957,596	68.3%
Surgeries — inpatient	53,271	34,340	55.1%	104,847	67,544	55.2%
Surgeries — outpatient	120,393	74,329	62.0%	231,099	142,538	62.1%
Total surgeries	173,664	108,669	59.8%	335,946	210,082	59.9%
Patient days — total	907,093	567,390	59.9%	1,836,257	1,170,675	56.9%
Adjusted patient days[1]	1,563,681	909,720	71.9%	3,089,060	1,849,560	67.0%
Average length of stay (days)	4.66	4.70	(0.9)%	4.72	4.75	(0.6)%
Average licensed beds	20,370	13,180	54.6%	20,313	13,180	54.1%
Utilization of licensed beds[2]	48.9%	47.3%	1.6%[3]	49.9%	49.1%	0.8%[3]
Total visits	2,066,051	1,072,712	92.6%	4,013,738	2,127,501	88.7%

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Paying visits (excludes charity and uninsured)	1,896,285	958,379	97.9%	3,678,724	1,902,928	93.3%
Charity and uninsured visits	169,766	114,333	48.5%	335,014	224,573	49.2%
Net inpatient revenues	$ 2,393	$ 1,542	55.2%	$ 4,833	$ 3,078	57.0%
Net outpatient revenues	$ 1,448	$ 844	71.6%	$ 2,794	$ 1,657	68.6%
Net inpatient revenue per admission	$ 12,294	$ 12,773	(3.8)%	$ 12,427	$ 12,479	(0.4)%
Net inpatient revenue per patient day	$ 2,638	$ 2,718	(2.9)%	$ 2,632	$ 2,629	0.1%
Net outpatient revenue per visit	$ 701	$ 787	(10.9)%	$ 696	$ 779	(10.7)%
Net patient revenue per adjusted patient admission[1]	$ 11,380	$ 12,208	(6.8)%	$ 11,533	$ 12,045	(4.3)%
Net patient revenue per adjusted patient day[1]	$ 2,456	$ 2,623	(6.4)%	$ 2,469	$ 2,560	(3.6)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.
(3) The change is the difference between the 2014 and 2013 amounts shown.

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The tables below show certain selected historical operating statistics of our continuing hospitals on a same-hospital basis, where noted, excluding the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, and Resolute Health Hospital, which we opened on June 24, 2014:

	Same-Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
Admissions, Patient Days and Surgeries	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total admissions	124,720	120,722	3.3%	249,171	246,651	1.0%
Adjusted patient admissions[1]	204,637	195,440	4.7%	401,492	393,105	2.1%
Paying admissions (excludes charity and uninsured)	116,801	111,891	4.4%	232,865	229,217	1.6%
Charity and uninsured admissions	7,919	8,831	(10.3)%	16,306	17,434	(6.5)%
Admissions through emergency department	80,529	75,608	6.5%	161,439	155,816	3.6%
Paying admissions as a percentage of total admissions	93.7%	92.7%	1.0%[2]	93.5%	92.9%	0.6%[2]
Charity and uninsured admissions as a percentage of total admissions	6.3%	7.3%	(1.0)%[2]	6.5%	7.1%	(0.6)%[2]
Emergency department admissions as a percentage of total admissions	64.6%	62.6%	2.0%[2]	64.8%	63.2%	1.6%[2]
Surgeries — inpatient	34,369	34,340	0.1%	67,898	67,544	0.5%
Surgeries — outpatient	89,783	74,329	20.8%	170,988	142,538	20.0%
Total surgeries	124,152	108,669	14.2%	238,886	210,082	13.7%
Patient days — total	584,251	567,390	3.0%	1,189,293	1,170,675	1.6%
Adjusted patient days[1]	948,144	909,720	4.2%	1,897,547	1,849,560	2.6%
Average length of stay (days)	4.68	4.70	(0.4)%	4.77	4.75	0.4%
Number of acute care hospitals (at end of period)	49	49	—	49	49	—
Licensed beds (at end of period)	13,231	13,180	0.4%	13,231	13,180	0.4%
Average licensed beds	13,196	13,180	0.1%	13,187	13,180	0.1%
Utilization of licensed beds[3]	48.7%	47.3%	1.4%[2]	49.8%	49.1%	0.7%[2]

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between 2014 and 2013 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

	Same-Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
Outpatient Visits	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total visits	1,140,595	1,072,712	6.3%	2,221,269	2,127,501	4.4%
Paying visits (excludes charity and uninsured)	1,031,920	958,379	7.7%	2,000,737	1,902,928	5.1%
Charity and uninsured visits	108,675	114,333	(4.9)%	220,532	224,573	(1.8)%
Emergency department visits	432,858	399,702	8.3%	847,051	801,780	5.6%
Surgery visits	89,783	74,329	20.8%	170,988	142,538	20.0%

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Paying visits as a percentage of total visits	90.5%	89.3%	1.2%[1]	90.1%	89.4%	0.7%[1]
Charity and uninsured visits as a percentage of total visits	9.5%	10.7%	(1.2)%[1]	9.9%	10.6%	(0.7)%[1]

[1] The change is the difference between 2014 and 2013 amounts shown.

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	Same-Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
Revenues	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Net operating revenues	$ 2,578	$ 2,422	6.4%	$ 5,091	$ 4,809	5.9%
Revenues from the uninsured	$ 147	$ 170	(13.5)%	$ 317	$ 335	(5.4)%
Net inpatient revenues[1]	$ 1,540	$ 1,542	(0.1)%	$ 3,109	$ 3,078	1.0%
Net outpatient revenues[1]	$ 927	$ 844	9.8%	$ 1,786	$ 1,657	7.8%

[1] Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $52 million and $69 million for the three months ended June 30, 2014 and 2013, respectively, and $125 million and $139 million for the six months ended June 30, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $95 million and $101 million for the three months ended June 30, 2014 and 2013, respectively, and $192 million and $196 million for the six months ended June 30, 2014 and 2013, respectively.

	Same-Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 12,348	$ 12,773	(3.3)%	$ 12,477	$ 12,479	—%
Net inpatient revenue per patient day	$ 2,636	$ 2,718	(3.0)%	$ 2,614	$ 2,629	(0.6)%
Net outpatient revenue per visit	$ 813	$ 787	3.3%	$ 804	$ 779	3.2%
Net patient revenue per adjusted patient admission[1]	$ 12,055	$ 12,208	(1.3)%	$ 12,192	$ 12,045	1.2%
Net patient revenue per adjusted patient day[1]	$ 2,602	$ 2,623	(0.8)%	$ 2,580	$ 2,560	0.8%

[1] Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

	Same-Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
Provision for Doubtful Accounts	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Provision for doubtful accounts	$ 209	$ 207	1.0%	$ 438	$ 414	5.8%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.5%	7.9%	(0.4)%[1]	7.9%	7.9%	—%[1]
Collection rate on self-pay accounts[2]	27.8%	28.7%	(0.9)%[1]	27.8%	28.7%	(0.9)%[1]
Collection rate on commercial managed care accounts	98.3%	98.2%	0.1%[1]	98.3%	98.2%	0.1%[1]

[1] The change is the difference between the 2014 and 2013 amounts shown.
[2] Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

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	Same-Hospital Continuing Operations					
	Three Months Ended June 30,			Six Months Ended June 30,		
Selected Operating Expenses	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Hospital Operations and other						
Salaries, wages and benefits	$ 1,103	$ 1,026	7.5%	$ 2,180	$ 2,060	5.8%
Supplies	413	387	6.7%	816	771	5.8%
Other operating expenses	601	514	16.9%	1,153	1,032	11.7%
Total	$ 2,117	$ 1,927	9.9%	$ 4,149	$ 3,863	7.4%
Conifer						

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Salaries, wages and benefits	$ 178	$ 140	27.1%	$ 349	$ 267	30.7%
Other operating expenses	63	53	18.9%	129	103	25.2%
Total	$ 241	$ 193	24.9%	$ 478	$ 370	29.2%
Total						
Salaries, wages and benefits	$ 1,281	$ 1,166	9.9%	$ 2,529	$ 2,327	8.7%
Supplies	413	387	6.7%	816	771	5.8%
Other operating expenses	664	567	17.1%	1,282	1,135	13.0%
Total	$ 2,358	$ 2,120	11.2%	$ 4,627	$ 4,233	9.3%
Rent/lease expense[1]						
Hospital Operations and other	$ 35	$ 39	(10.3)%	$ 68	$ 77	(11.7)%
Conifer	5	3	66.7%	11	7	57.1%
Total	$ 40	$ 42	(4.8)%	$ 79	$ 84	(6.0)%
Hospital Operations and other[2]						
Salaries, wages and benefits per adjusted patient day	$ 1,161	$ 1,128	2.9%	$ 1,147	$ 1,114	3.0%
Supplies per adjusted patient day	436	425	2.6%	430	417	3.1%
Other operating expenses per adjusted patient day	615	565	8.8%	589	558	5.6%
Total per adjusted patient day	$ 2,212	$ 2,118	4.4%	$ 2,166	$ 2,089	3.7%
Salaries, wages and benefits per adjusted patient admission	$ 5,380	$ 5,250	2.5%	$ 5,420	$ 5,240	3.4%
Supplies per adjusted patient admission	2,018	1,980	1.9%	2,032	1,961	3.6%
Other operating expenses per adjusted patient admission	2,849	2,630	8.3%	2,787	2,626	6.1%
Total per adjusted patient admission	$ 10,247	$ 9,860	3.9%	$ 10,239	$ 9,827	4.2%

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

THREE MONTHS ENDED JUNE 30, 2014 COMPARED TO THREE MONTHS ENDED JUNE 30, 2013

Revenues

During the three months ended June 30, 2014, same-hospital net operating revenues after provision for doubtful accounts increased 6.4% compared to the three months ended June 30, 2013, primarily due to improved terms of our managed care contracts, higher inpatient and outpatient volumes, and an increase in our other operations revenues.

Our same-hospital net outpatient revenues and total outpatient visits increased 9.8% and 6.3%, respectively, during the three months ended June 30, 2014 compared to the same period in 2013. Outpatient revenues and volume growth was primarily driven by improved terms of our managed care contracts, increased outpatient volume levels and our outpatient acquisition program. Net outpatient revenue per visit increased 3.3% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $285 million and $219 million for the three months ended June 30, 2014 and 2013, respectively, a portion of which was eliminated in consolidation as described in Note 15 to the Condensed Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients and expanded service offerings.

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Same-hospital patient days increased by 3.0% during the three months ended June 30, 2014 compared to the three months ended June 30, 2013. We believe our volumes were positively impacted by incremental market share as a result of improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy. We believe our growth in inpatient volume levels continues to be constrained by an increase in patients with high-deductible health insurance plans and industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than in an inpatient setting.

Provision for Doubtful Accounts

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.5% for the three months ended June 30, 2014 compared to 7.9% for the three months ended June 30, 2013. The decrease in the provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts primarily related to the decrease in uninsured patient revenues, partially offset by the 90 basis point decrease in our self-pay collection rate, as well as higher patient co-pays and deductibles. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at June 30, 2014 and December 31, 2013:

	June 30, 2014	December 31, 2013

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	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 353	$ —	$ 353	$ 309	$ —	$ 309
Medicaid	157	—	157	141	—	141
Net cost report settlements payable and valuation allowances	(118)	—	(118)	(77)	—	(77)
Managed care	1,403	80	1,323	1,240	69	1,171
Self-pay uninsured	516	429	87	344	290	54
Self-pay balance after insurance	221	135	86	224	141	83
Estimated future recoveries from accounts assigned to our Conifer subsidiary	90	—	90	91	—	91
Other payers	299	109	190	279	89	190
Total continuing operations	2,921	753	2,168	2,551	589	1,962
Total discontinued operations	3	—	3	3	—	3
	$ 2,924	$ 753	$ 2,171	$ 2,554	$ 589	$ 1,965

We provide revenue cycle management and patient communications services, among others, through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have increased our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology, and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years, as we have experienced adverse changes in our business mix. At June 30, 2014, our same-hospital collection rate on self-pay accounts was approximately 27.8%. Our recent same-hospital self-pay collection rates were as follows: 28.8% at March 31, 2013; 28.7% at June 30, 2013; 28.8% at September 30, 2013; 28.7% at December 31, 2013; and 28.1% at March 31, 2014. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at June 30, 2014, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $11 million.

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Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated same-hospital collection rate from managed care payers was approximately 98.3% at both June 30, 2014 and December 31, 2013.

Conifer continues to focus on revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collection at point-of-service, and financial counseling. The goals of the effort are focused on reducing denials, improving service levels to patients and increasing the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) accounts receivable days outstanding ("AR Days"), and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from continuing operations of $2.286 billion and $2.039 billion at June 30, 2014 and December 31, 2013, respectively, excluding cost report settlements payable and valuation allowances of $118 million and $77 million at June 30, 2014 and December 31, 2013, respectively:

	June 30, 2014				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	80%	51%	66%	28%	61%
61-120 days	8%	18%	15%	21%	15%
121-180 days	5%	10%	6%	12%	7%
Over 180 days	7%	21%	13%	39%	17%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

	December 31, 2013				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	76%	58%	73%	32%	65%
61-120 days	9%	21%	13%	17%	14%
121-180 days	4%	9%	5%	7%	6%
Over 180 days	11%	12%	9%	44%	15%

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Total	**100%**	**100%**	**100%**	**100%**	**100%**

Our AR Days from continuing operations were 48.9 days at June 30, 2014 and 46.5 days at December 31, 2013, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of June 30, 2014, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $3.0 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medicaid Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. At the present time, our new acquisitions are beginning to implement this program. Based on recent trends, approximately 94% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at June 30, 2014 and December 31, 2013 by aging category on a same-hospital basis:

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	June 30, 2014	December 31, 2013
0-60 days	$ 84	$ 132
61-120 days	25	28
121-180 days	10	8
Over 180 days	19	18
Total	**$ 138**	**$ 186**

Salaries, Wages and Benefits

Salaries, wages and benefits expense as a percentage of net operating revenues increased 0.3% for the three months ended June 30, 2014 compared to the three months ended June 30, 2013. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 2.5% in the three months ended June 30, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs. Salaries, wages and benefits expense for the three months ended June 30, 2014 and 2013 included stock-based compensation expense of $14 million and $9 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $38 million in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

As of June 30, 2014, approximately 20% of our employees were represented by labor unions. These employees — primarily registered nurses and service and maintenance workers — are located at 39 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have four expired contracts and are negotiating renewals under extension agreements. We are also negotiating a first contract at one of our hospitals where employees selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014.

Supplies

Supplies expense as a percentage of net operating revenues increased 0.1% for the three months ended June 30, 2014 compared to the three months ended June 30, 2013. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 1.9% in the three months ended June 30, 2014 compared to the same period in 2013. The change in supplies expense per adjusted patient admission was primarily attributable to higher costs for pharmaceuticals and volume growth in our supply-intensive surgical services.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, bulk purchases and operational improvements. The items of current cost reduction focus continue to be cardiac stents and pacemakers, orthopedics and implants, and high-cost pharmaceuticals. We also utilize group-purchasing strategies and supplies-management services in an effort to reduce costs.

Other Operating Expenses, Net

Other operating expenses as a percentage of net operating revenues was 25.5% in the three months ended June 30, 2014 compared to 23.4% in the three months ended June 30, 2013. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 8.3% in the three months ended June 30, 2014 compared to the same period in 2013. The 16.9% increase in same-hospital other operating expenses in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 is primarily due to:

- increased costs of contracted services ($8 million);
- higher medical fees primarily related to a greater number of employed and contracted physicians ($19 million); and

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- increased malpractice expense ($31 million).

Malpractice expense in the three months ended June 30, 2014 included isolated unfavorable case reserve adjustments related to a small number of claims, as well as an unfavorable adjustment of approximately $1 million due to a 17 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to favorable adjustment of approximately $6 million as a result of a 72 basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $10 million in the three months ended June 30, 2014 compared to the three months ended June 30, 2013 primarily due to higher costs related to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

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Impairment and Restructuring Charges, and Acquisition-Related Costs

During the three months ended June 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $32 million, consisting of $3 million of employee severance costs, $13 million of restructuring costs, and $16 million in acquisition-related costs, which include both transaction costs and acquisition integration charges.

During the three months ended June 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $11 million, consisting of $2 million of impairment of property, $3 million of employee severance costs and $6 million in acquisition-related costs.

Litigation and Investigation Costs

Litigation and investigation costs for the three months ended June 30, 2014 and 2013 were $12 million and $2 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

Interest Expense

Interest expense for the three months ended June 30, 2014 was $190 million compared to $98 million for the three months ended June 30, 2013, primarily due to increased borrowings relating to our recent acquisitions.

Loss from Early Extinguishment of Debt

During the three months ended June 30, 2013, we recorded a loss from early extinguishment of debt of $171 million, related to the difference between the purchase prices and the par values of the $925 million aggregate principal amount of our 8$^{7}/_{8}$% senior secured notes due 2019 that we purchased and called during the period, as well as the write-off of associated unamortized note discounts and issuance costs.

Income Tax (Benefit) Expense

During the three months ended June 30, 2014, we recorded income tax expense of $8 million compared to a benefit of $20 million, primarily related to the loss from early extinguishment of debt, during the three months ended June 30, 2013.

SIX MONTHS ENDED JUNE 30, 2014 COMPARED TO SIX MONTHS ENDED JUNE 30, 2013

Revenues

During the six months ended June 30, 2014, same-hospital net operating revenues after provision for doubtful accounts increased 5.9% compared to the six months ended June 30, 2013, primarily due to improved terms of our managed care contracts, higher inpatient and outpatient volumes, and an increase in our other operations revenues.

Our same-hospital net outpatient revenues and total outpatient visits increased 7.8% and 4.4%, respectively, during the six months ended June 30, 2014 compared to the same period in 2013. Outpatient revenues and volume growth was primarily driven by improved terms of our managed care contracts, increased outpatient volume levels and our outpatient acquisition program. Net outpatient revenue per visit increased 3.2% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $570 million and $430 million for the six months ended June 30, 2014 and 2013, respectively, a portion of which was eliminated in consolidation as described in Note 15 to the Condensed Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients and expanded service offerings.

Same-hospital patient days increased by 1.6% during the six months ended June 30, 2014 compared to the six months ended June 30, 2013. We believe our volumes were positively impacted by incremental market share as a result of improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy. We believe our growth in inpatient volume levels continues to be constrained by an increase in patients with high-deductible health insurance plans and industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than in an inpatient setting.

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Provision for Doubtful Accounts

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The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.9% for both the six months ended June 30, 2014 and 2013. The provision for doubtful accounts was favorably impacted by decreased uninsured patient revenues, offset by the unfavorable impact of the 90 basis point decrease in our self-pay collection rate, as well as higher patient co-pays and deductibles.

Salaries, Wages and Benefits

Salaries, wages and benefits expense as a percentage of net operating revenues increased 0.3% for the six months ended June 30, 2014 compared to the six months ended June 30, 2013. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 3.4% in the six months ended June 30, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs. Salaries, wages and benefits expense for the six months ended June 30, 2014 and 2013 included stock-based compensation expense of $26 million and $20 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $82 million in the six months ended June 30, 2014 compared to the six months ended June 30, 2013 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Supplies

Supplies expense as a percentage of net operating revenues remained flat for the six months ended June 30, 2014 compared to the six months ended June 30, 2013. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 3.6% in the six months ended June 30, 2014 compared to the same period in 2013. The change in supplies expense per adjusted patient admission was primarily attributable to higher costs for pharmaceuticals and volume growth in our supply-intensive surgical services.

Other Operating Expenses, Net

Other operating expenses as a percentage of net operating revenues was 25.5% in the six months ended June 30, 2014 compared to 23.6% in the six months ended June 30, 2013. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 6.1% in the six months ended June 30, 2014 compared to the same period in 2013. The 11.7% increase in same-hospital other operating expenses in the six months ended June 30, 2014 compared to the six months ended June 30, 2013 is primarily due to:

- increased costs of contracted services ($15 million);
- higher medical fees primarily related to a greater number of employed and contracted physicians ($36 million);
- increased malpractice expense ($37 million); and
- decreased rent and lease expense ($9 million).

Malpractice expense in the six months ended June 30, 2014 included isolated unfavorable case reserve adjustments related to a small number of claims, as well as an unfavorable adjustment of approximately $2 million due to a 32 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to favorable adjustment of approximately $7 million as a result of a 78 basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $26 million in the six months ended June 30, 2014 compared to the six months ended June 30, 2013 primarily due to higher costs related to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the six months ended June 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $53 million, consisting $9 million of employee severance costs, $18 million of restructuring costs, and $26 million in acquisition-related costs, which include $4 million of transaction costs and $22 million of acquisition integration charges.

During the six months ended June 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $25 million, consisting of $2 million of impairment of property, $7 million of restructuring costs, $5 million of employee severance costs, $1 million of lease termination costs, and $10 million in acquisition-related costs.

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Litigation and Investigation Costs

Litigation and investigation costs for the six months ended June 30, 2014 and 2013 were $15 million and $2 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

Interest Expense

Interest expense for the six months ended June 30, 2014 was $372 million compared to $201 million for the six months ended June 30, 2013, primarily due to increased borrowings relating to our recent acquisitions and $400 million of share repurchases during 2013.

Loss from Early Extinguishment of Debt

During the six months ended June 30, 2013, we recorded a loss from early extinguishment of debt of $348 million consisting of $177 million related

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to the difference between the purchase prices and the par values of the $714 million aggregate principal amount of our $10% senior secured notes due 2018 that we purchased and called during the period, as well as the write-off of associated unamortized note discounts and issuances costs, and $171 million related to the difference between the purchase prices and the par values of the $925 million aggregate principal amount of our 8 7/8% senior secured notes due 2019 that we purchased and called during the period, as well as the write-off of associated unamortized note discounts and issuance costs.

Income Tax (Benefit) Expense

During the six months ended June 30, 2014, we recorded income tax expense of $7 million compared to a benefit of $73 million, primarily related to the loss from early extinguishment of debt, during the six months ended June 30, 2013.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

The financial information provided throughout this report, including our Condensed Consolidated Financial Statements and the notes thereto, has been prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). However, we use certain non-GAAP financial measures defined below in communications with investors, analysts, rating agencies, banks and others to assist such parties in understanding the impact of various items on our financial statements, some of which are recurring or involve cash payments. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure that we use in our analysis of the performance of our business, which we define as net income (loss) attributable to our common shareholders before: (1) the cumulative effect of changes in accounting principle, net of tax; (2) net loss (income) attributable to noncontrolling interests; (3) preferred stock dividends; (4) income (loss) from discontinued operations, net of tax; (5) income tax benefit (expense); (6) investment earnings (loss); (7) gain (loss) from early extinguishment of debt; (8) net gain (loss) on sales of investments; (9) interest expense; (10) litigation and investigation benefit (costs), net of insurance recoveries; (11) hurricane insurance recoveries, net of costs; (12) impairment and restructuring charges and acquisition-related costs; and (13) depreciation and amortization. As is the case with all non-GAAP measures, investors should consider the limitations associated with this metric, including the potential lack of comparability of this measure from one company to another, and should recognize that Adjusted EBITDA does not provide a complete measure of our operating performance because it excludes many items that are included in our financial statements. Accordingly, investors are encouraged to use GAAP measures when evaluating our financial performance.

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The table below shows the reconciliation of Adjusted EBITDA to net loss attributable to our common shareholders (the most comparable GAAP term) for the three and six months ended June 30, 2014 and 2013:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2013	2014	2013
Net loss attributable to Tenet Healthcare Corporation common shareholders	$ (26)	$ (50)	$ (58)	$ (138)
Less: Net income attributable to noncontrolling interests	(19)	(7)	(35)	(12)
Income (loss) from discontinued operations, net of tax	(16)	3	(21)	1
Income (loss) from continuing operations	9	(46)	(2)	(127)
Income tax benefit (expense)	(8)	20	(7)	73
Investment earnings	—	1	—	1
Loss from early extinguishment of debt	—	(171)	—	(348)
Interest expense	(190)	(98)	(372)	(201)
Operating income	207	202	377	348
Litigation and investigation costs	(12)	(2)	(15)	(2)
Impairment and restructuring charges, and acquisition-related costs	(32)	(11)	(53)	(25)
Depreciation and amortization	(209)	(121)	(402)	(235)
Adjusted EBITDA	**$ 460**	**$ 336**	**$ 847**	**$ 610**
Net operating revenues	**$ 4,042**	**$ 2,422**	**$ 7,968**	**$ 4,809**
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	**11.4%**	**13.9%**	**10.6%**	**12.7%**

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

There have been no material changes to our obligations to make future cash payments under contracts and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, as disclosed in our Annual Report, except for (i) a $286 million aggregate commitment for a long-term arrangement we entered into during the three months ended June 30, 2014 for future professional services to be provided to us and licensed software fees related to our health information technology initiatives and future ongoing information technology services for the 28 Vanguard hospitals we acquired in October 2013, and (ii) our recently issued 5% senior notes discussed under the caption "Debt Instruments, Guarantees and Related Covenants" below.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our cash and our operating results. At June 30, 2014, using the last 12 months of Adjusted EBITDA, including Vanguard's last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 6.6x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including acquisitions that involve the assumption of long-term debt. We intend to manage this ratio by following our business plan, managing our cost structure and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are

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described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements. Capital expenditures were $523 million and $256 million in the six months ended June 30, 2014 and 2013, respectively. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2014 will total approximately $900 million to $1 billion, including $193 million that was accrued as a liability at December 31, 2013. Our budgeted 2014 capital expenditures include approximately $18 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree. We expect to spend approximately $18 million more on such improvements over the next two years.

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During the six months ended June 30, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas. We also acquired three ambulatory surgery centers, three urgent care centers, one diagnostic imaging center and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions was $42 million.

Interest payments, net of capitalized interest, were $360 million and $226 million in the six months ended June 30, 2014 and 2013, respectively.

Income tax payments, net of tax refunds, were approximately $19 million in the six months ended June 30, 2014 compared to $8 million in the six months ended June 30, 2013.

SOURCES AND USES OF CASH

Our liquidity for the six months ended June 30, 2014 was primarily derived from net cash provided by operating activities, cash on hand, issuance of long term debt and borrowings under our revolving credit facility. We had approximately $406 million of cash and cash equivalents on hand at June 30, 2014 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $994 million based on our borrowing base calculation as of June 30, 2014.

Our primary source of operating cash is the collection of accounts receivable. As such, our operating cash flow is impacted by levels of cash collections and levels of bad debt due to shifts in payer mix and other factors.

Net cash provided by operating activities was $247 million in the six months ended June 30, 2014 compared to $128 million in the six months ended June 30, 2013. Key positive and negative factors contributing to the change between the 2014 and 2013 periods include the following:

- Increased income from continuing operations before income taxes of $237 million, excluding loss from early extinguishment of debt, interest expense, investment earnings, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization, in the six months ended June 30, 2014 compared to the six months ended June 30, 2013;
- The favorable impact of a reduction of approximately $44 million in net amounts we are owed under Medicaid supplemental programs in the 2014 period;
- $5 million more cash used in operating activities from discontinued operations;
- Income tax payments of $19 million in the six months ended June 30, 2014 compared to $8 million in the six months ended June 30, 2013;
- An increase of $65 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- Higher interest payments of $134 million.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash. These initiatives may include the sale of excess land, buildings or other underutilized or inefficient assets.

Capital expenditures were $523 million and $256 million in the six months ended June 30, 2014 and 2013, respectively.

We record our investments that are available-for-sale at fair market value. As shown in Note 13 to the Condensed Consolidated Financial Statements, the majority of our investments are valued based on quoted market prices or other observable inputs. We believe we have no investments that will be negatively affected by the slow economic recovery such that they will materially impact our financial condition, results of operations or cash flows.

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DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

We have a senior secured revolving credit facility (as amended, "Credit Agreement") that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016. We are in compliance with all covenants and conditions in our Credit Agreement. At June 30, 2014, we had no cash borrowings outstanding under the revolving credit facility; however, we had approximately $6 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $994 million was available for borrowing under the revolving credit facility at June 30, 2014.

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Standby letters of credit are required principally by our insurers and various states to collateralize our workers' compensation programs pursuant to statutory requirements and as security to collateralize the deductible and self-insured retentions under certain of our professional and general liability insurance programs. The amount of collateral required is primarily dependent upon the level of claims activity and our creditworthiness. The insurers require the collateral in case we are unable to meet our obligations to claimants within the deductible or self-insured retention layers. On March 7, 2014, we entered into a new letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our existing Credit Agreement, which we transferred to the LC Facility), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. At June 30, 2014, we had approximately $133 million of standby letters of credit outstanding under the LC Facility.

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, commencing on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 9 1/4% senior notes due 2015 in July 2014. The proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement. For information regarding our long-term debt and capital lease obligations, see Note 5 to our Condensed Consolidated Financial Statements.

LIQUIDITY

From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time. We believe our existing debt agreements, the significant recent changes to which are described above, provide significant flexibility for future secured or unsecured borrowings.

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest and income tax payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that has caused, and in the future could cause, us to use our senior secured revolving credit facility as a source of liquidity. We believe that existing cash and cash equivalents on hand, availability under our revolving credit facility, anticipated future cash provided by operating activities, and our investments in marketable securities of our captive insurance companies classified as noncurrent investments on our balance sheet should be adequate to meet our current cash needs. These sources of liquidity should also be adequate to finance planned capital expenditures, payments on the current portion of our long-term debt and other presently known operating needs.

Long-term liquidity for debt service will be dependent on improved cash provided by operating activities and, given favorable market conditions, future borrowings or refinancings. However, our cash requirements could be materially affected by the use of cash in acquisitions of businesses and repurchases of securities, and also by a deterioration in our results of operations, as well as the various uncertainties discussed in this and other sections of this report, which could require us to pursue any number of financing options, including, but not limited to, additional borrowings, debt refinancings, asset sales or other financing alternatives. The level, if any, of these financing sources cannot be assured.

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our period-end balance sheets. We do not have any significant European sovereign debt exposure.

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are volume growth, including the acquisition of outpatient businesses, physician recruitment and alignment strategies, expansion of our services businesses within Conifer, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, underperforming hospitals and health plans, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management peers because of geographic and other differences in hospital portfolios.

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OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the six months ended June 30, 2014 and 2013 include $218 million and $485 million, respectively, of net operating revenues and $36 million and $70 million, respectively, of operating income generated from general hospitals operated by us under operating lease arrangements (two hospitals as of June 30, 2014 and four hospitals as of June 30, 2013). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet. The current terms of these leases expire in 2027 and 2029. If we are unable to extend these leases or purchase the hospitals, we would no longer generate revenues or expenses from such hospitals.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $236 million of standby letters of credit outstanding and guarantees as of June 30, 2014.

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed Consolidated Financial Statements in conformity with GAAP, we must use estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable, given the particular circumstances in which we operate. Actual results may vary from those estimates.

We consider our critical accounting estimates to be those that (1) involve significant judgments and uncertainties, (2) require estimates that are more difficult for management to determine, and (3) may produce materially different outcomes under different conditions or when using different assumptions.

Our critical accounting estimates have not changed from the description provided in our Annual Report.

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ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments as of June 30, 2014. The fair values were determined based on quoted market prices for the same or similar instruments. The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2014	2015	2016	2017	2018	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 113	$ 551	$ 37	$ 52	$ 1,049	$ 9,781	$ 11,583	$ 12,466
Average effective interest rates	8.5%	9.1%	6.6%	8.7%	6.6%	6.8%	6.9%	

At June 30, 2014, we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as "special-purpose" or "variable-interest" entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements by us. Thus, we have no exposure to the financing, liquidity, market or credit risks associated with such entities.

We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage or prepayment features.

ITEM 4. CONTROLS AND PROCEDURES

We carried out an evaluation of the effectiveness of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended, as of the end of the period covered by this report. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, the chief executive officer and chief financial officer concluded that, as of the end of the period covered by this report, our disclosure controls and procedures are effective in ensuring that information required to be disclosed in our Securities Exchange Act reports is recorded, processed, summarized and reported in a timely manner and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosure.

There were no changes in our internal control over financial reporting during the quarter ended June 30, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

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PART II. OTHER INFORMATION
ITEM 1. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 10 to our Condensed Consolidated Financial Statements, which is incorporated by reference. In addition to those matters, as previously disclosed in our Annual Report on Form 10-K for the year ended December 31, 2013, our Conifer Health Solutions, LLC subsidiary ("Conifer") received a Civil Investigative Demand ("CID") in August 2013 from the U.S. Consumer Financial Protection Bureau ("CFPB") that required Conifer to provide to the CFPB a broad range of information regarding its debt collection activities, including its internal compliance procedures. In July 2014, the CFPB issued a second CID seeking information regarding Conifer's compliance with certain notification and other requirements under federal consumer financial laws. Conifer is cooperating with the CFPB in providing the requested information. At this time, we are unable to predict the outcome of this CFPB investigation, including whether the investigation will result in any action or proceeding against Conifer. The CFPB has the authority to impose fines, require operational changes or take other actions if it determines that a violation of the Fair Debt Collection Act has occurred.

ITEM 6. EXHIBITS

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Exchange and Registration Rights Agreement, dated as of June 25, 2014, between the Registrant and Barclays Capital Inc., as representative of the initial purchasers (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed June 25, 2014)

(10) Material Contracts

(a) Fifth Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 4.1 to Registrant's Registration Statement on Form S-8, filed May 23, 2014)*

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Trevor Fetter, President and Chief Executive Officer

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(b) Certification of Daniel J. Cancelmi, Chief Financial Officer

(32) Section 1350 Certification of Trevor Fetter, President and Chief Executive Officer, and Daniel J. Cancelmi, Chief Financial Officer

(101 INS) XBRL Instance Document

(101 SCH) XBRL Taxonomy Extension Schema Document

(101 CAL) XBRL Taxonomy Extension Calculation Linkbase Document

(101 DEF) XBRL Taxonomy Extension Definition Linkbase Document

(101 LAB) XBRL Taxonomy Extension Label Linkbase Document

(101 PRE) XBRL Taxonomy Extension Presentation Linkbase Document

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* Management contract or compensatory plan or arrangement.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: August 4, 2014

By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

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Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Trevor Fetter, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: August 4, 2014

/s/ TREVOR FETTER
Trevor Fetter
President and Chief Executive Officer

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Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: August 4, 2014

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

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Exhibit 32

Certifications Pursuant to Section 1350 of Chapter 63 of Title 18 of the United States Code

We, the undersigned Trevor Fetter and Daniel J. Cancelmi, being, respectively, the President and Chief Executive Officer and the Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014 (the "Form 10-Q"), to be filed with the Securities and Exchange Commission on the date hereof, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, and (ii) the information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: August 4, 2014

/s/ TREVOR FETTER
Trevor Fetter
President and Chief Executive Officer

Date: August 4, 2014

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.

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EXHIBIT 17 – ENDOWMENT AND OTHER CHARITABLE FUNDS

EXHIBIT 17
ECHN ENDOWMENT AND OTHER CHARITABLE FUNDS

Explanatory Notes:

1. ECHN has provided a copy of each available gift instrument. In some cases, although it conducted a thorough review of its records as well as the records of local probate courts, it was unable to locate the original gift instrument. In those cases, it has provided other available documentation of the gifts, including copies of minutes of Board meetings and/or copies of old audited financials.
2. References to the 1990 Report of the Attorney General are to the June, 1990 Report of the Office of the Attorney General on Hospital Bed Fund Trusts.
3. Proposed requests for cy pres relief will apply to the balances of the funds remaining at the time and not appropriated or used by ECNH for proper purposes.

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
MANCHESTER MEMORIAL HOSPITAL								
	Endowment: Unrestricted Income Funds							
17-1	Dwight W. Blish Fund	$19,920	$189,827	Devise under Article Fourth of the Last Will and Testament of Dwight W. Blish dated September 6, 1923, with Codicil dated July 3, 1933	Upon the deaths of Mr. Blish's wife and son, the testamentary trust he had established for their benefit terminated, and the property then remaining was given outright "to The Manchester Memorial Hospital to be held by the trustees of said hospital as a trust fund to be known as the Dwight W. Blish fund, the income therefrom to be used for such purposes in connection with said hospital as the trustees shall decide." Income unrestricted	The Last Will and Testament of Dwight W. Blish dated September 6, 1923; and Codicil dated July 3, 1933		Request cy pres relief and transfer to the new Foundation
17-2	John & Eliza Carpenter	$2,555	$110,452	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995		Request cy pres relief and transfer to the new Foundation
17-3	Helen G. Chapman	$5,000	$81,544	Bequest under Article FOURTH of the Last Will and Testament of Helen G. Chapman dated July 1, 1938	Bequest of $5,000 "to the Manchester Memorial Hospital, of Manchester, Connecticut, to be held by it in perpetuity, with power of investment, sale and reinvestment, and to apply the income only for the support of the Hospital maintained by it in the town of Manchester." Income unrestricted	The Last Will and Testament of Helen G. Chapman dated July 1, 1938		Request cy pres relief and transfer to the new Foundation
17-4	William H. Coates (Costes)	$500	$5,545	Bequest under the Last Will and Testament of William H. Coates (date unknown)	This bequest is documented in the minutes of the August 12, 1925 meeting of the Board of Trustees of the Hospital, which state that "A report was given by the Manchester Trust Company, Executor of the will of William H. Coates, of a gift of $500.00, the interest only to be used for hospital purposes." This bequest is also referenced in a document titled "Exhibit A - Report of the Finance Committee" apparently excerpted from Board minutes. That Exhibit also classifies this fund as an endowment fund and states [the income is to be used] "...as the trustees of said hospital may deem best..." Income unrestricted	Minutes of the August 12, 1925 meeting of the Board of Trustees; and "Exhibit A - Report of the Finance Committee" from other Board minutes.	Note: This fund has sometimes (incorrectly) been identifed as a gift from William H. Costes rather than William H. Coates.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-5	Grace K. Dart	$4,007	$173,181	Devise under ARTICLE VI. of the Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931.	Devise of half the residuary estate. Article VI. provides as follows: All the rest, residue and remainder of my property, both real and personal, wherever it may be situated and of whatsoever it may consist I direct be divided into two (2) equal parts. The first of said equal parts, I give, devise and bequeath to The Manchester Memorial Hospital, a Connecticut Corporation, located in said Manchester, to take, hold, manage, invest and reinvest and to use the income therefrom for the general running expenses of said Hospital. Income unrestricted	The Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931		Request cy pres relief and transfer to the new Foundation
17-6	The Grace L. House Fund	$2,500	$30,055	Bequest under Article VI. of the Last Will and Testament of Charles E. House dated May 4, 1933	Bequest to the Hospital of $2500 "to be held by said Hospital as a permanent fund, and to be know[n] as "The Grace L. House Fund". The income therefrom is to be used for the running expenses of said Hospital." Income unrestricted	The Last Will and Testament of Charles E. House dated May 4, 1933		Request cy pres relief and transfer to the new Foundation
17-7	The John Porter & Caroline E. Porter Fund	$7,464	$322,608	Devise under Paragraph EIGHTH (c) of the Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937. Devise under Article SIXTH (f) of the Last Will and Testament of Caroline E. Porter, dated July 3, 1956.	Devise of a share in the residue of a testamentary trust established by the Will of John Porter as follows: "Twenty per cent. (20%) [of this trust], ..., I give in equal shares to the following fourteen charitable institutions, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz.: ...13. The Manchester Memorial Hospital, of Manchester,..." Subsequent devise by Caroline E. Porter of a portion of another testamentary trust established under the Will of John Porter through her exercise of a power of appointment over one-half of the trust as follows:: "SIXTH: ... Accordingly,...., I nominate and appoint [the following] to receive out of said one-half of said residuary estate of my late husband, John Porter, the following gifts, to wit: ... (f) The balance ...shall be distributed by said trustees in equal shares to the following fourteen charitable institutions, ..., in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz: ...13. The Manchester Memorial Hospital, of Manchester, Connecticut;..." Income unrestricted	The Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937; the Last Will and Testament of Caroline E. Porter, dated July 3, 1956; and May 23, 1958, letter from Hartford National Bank and Trust Company to Robert Hathaway of the Manchester Trust Company.		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-8	William & Mary Rice Fund	$122,361	$1,195,489	Devise under Article FOURTH of the Last Will and Testament of Richard W. Rice dated April 11, 1924	Upon the deaths of the last named life beneficiary, the testamentary trust Mr. Rice had established terminated, "... and the principal thereof, and all accumulations thereto, I give, devise and bequeath to the Manchester Memorial Hospital, of Manchester, Connecticut, in trust, to be known as the William and Mary Rice Fund, the income therefrom to be used for the purposes of uses of said Hospital." Income unrestricted	The Last Will and Testament of Richard W. Rice dated April 11, 1924		Request cy pres relief and transfer to the new Foundation
17-9	Robert N. and Florella Stanley Trust Fund	$3,000	$33,892	Bequest under ARTICLE V. of the Last Will and Testament of Flora May Stanley dated December 2, 1940	Bequest of $3000 to The Manchester Memorial Hospital, a Connecticut corporation, "... to be known as the Robert N. and Florella Stanley Trust Fund, to be added to the Endowment Fund of said hospital, and the income to be used for such purposes as the Trustees may deem best." Income unrestricted	The Last Will and Testament of Flora May Stanley dated December 2, 1940		Request cy pres relief and transfer to the new Foundation
17-10	George W. Strant and Rose B. Strant Memorial Fund	$128,043	$941,502	Two bequests and a share in the residuary estate as follows: (1) Bequest under Article THIRD 1. of the Last Will and Testament of Rose B. Strant dated December 22, 1954; (2) Bequest under Article THIRD 6. of said Will; and (3) Devise of a share in the residuary estate under Article FOURTH a. of said Will	Rose Strant left three testamentary gifts to Manchester Memorial Hospital, all of which were to the Hospital's endowment,"the income only from which is to be used for the general purposes of said hospital." The Bequest (in Article THIRD 1(b) and (c)) was the remainder interest in a $2000 trust or, if the life beneficary predeceased her, $2000: "b. Upon the death of [my cousin] "... said trust shall thereupon terminate and ...the principal of said trust, together with any unpaid income, [shall] be paid to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and the income only from which is to be used for the general purposes of said hospital. c. If my said cousin... shall predecease me, then in that event, I give and bequeath said Two Thousand (($2,000.00) Dollars to the Manchester Memorial Hospital, to be used as set forth above. Article THIRD 6. bequeathed "the sum of Five Thousand ($5,000.00) Dollars to the Manchester Memorial Hospital, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Article FOURTH A. left two of three three equal parts "to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and to be known as the Geroge W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Income unrestricted	The Last Will and Testament of Rose B. Strant dated December 22, 1954		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-11	Minnie R. Strickland	$2,511	$108,536	Devise under ARTICLE IX of the Last Will and Testament of Minnie R. Strickland dated June 29, 1942	Devise of one-third of the residuary estate pursuant to Article IX, which provides as follows: "I direct that all the rest and residue of my property of whatever kind and wherever situated shall be divided into three (3) equal parts: I give one of said equal parts to the Manchester Memorial Hospital; of Manchester, Conn., to be added to the Endowment Fund of said Hospital;..." Income unrestricted	The Last Will and Testament of Minnie R. Strickland dated June 29, 1942		Request cy pres relief and transfer to the new Foundation
17-12	Arthur B. and Carrie E. Ellis Trust Fund	$5,000	$55,532	Bequest under ARTICLE IV. of the Last Will and Testament of Carrie E. Ellis dated February 9, 1940, with Codicil dated October 8, 1942	Bequest to The Manchester Memorial Hospital of "the sum of Five Thousand ($5,000.00) Dollars, to be added to the Endowment Fund of said hospital and to be known as "The Arthur B. and Carrie E. Ellis Trust Fund", the income therefrom to be used for such hospital purposes as its Trustees may desire." Income unrestricted	The Last Will and Testament of Carrie E. Ellis dated February 9, 1940; Codicil dated October 8, 1942		Request cy pres relief and transfer to the new Foundation
17-13	Ralph and Lula Pinney Fund	$31,031	$462,104	Devise under Article 7th.of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income unrestricted as to this part of the gift; see also Fund 17-27	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 17-27.	Request cy pres relief and transfer to the new Foundation
17-14	Emil L. G. Hohenthal	$750	$7,729	Unknown	This fund is documented in the June 16, 1953 minutes of a meeting of the Board of Trustees of the Hospital. The minutes do not quote or refer to gift language, but state that the "original amount" of the gift was $750, and the context suggests that this is an endowment. This fund has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	The minutes of the June 16, 1953 meeting of the Board of Trustees of the Hospital; the financial records of the Hospital.	Note: The Hospital located the Last Will and Testament of Mr. Hohenthal's wife Hazel, but it did not include this gift.	Request cy pres relief and transfer to the new Foundation
17-15	George Wells Cheney and Harriet Richmond Cheney Memorial Fund	$75,000	$823,226	Devise under Article SEVENTH C. of the Last Will and Testament of Louis R. Cheney dated February 22, 1944	Devise of a share in the residuary estate as follows: "Seventh: I direct my Executors to divide all the rest, residue and remainder of my property both real and personal, and wheresoever situated including any property over which I may have power of disposal or appointment, into one Hundred Fifty-five (155) equal parts, and I give, bequeath and devise said parts as follows: ... C. Ten (10) of said parts to the Manchester Memorial Hospital as a memorial to my father and mother, George Wells Cheney and Harriet Richmond Cheney, to be held as a separate fund and the income only used for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Louis R. Cheney dated February 22, 1944		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-16	Helen Campbell Cheney Fund	$543,562	$4,653,131	Devise under Article Sixth (b) of the Last Will and Testament of Helen Campbell Cheney dated June 29, 1960	Devise of a share in the residuary estate as follows: "Sixth: All the rest, residue and remainder of my estate, both real and personal and wherever situated, I direct my Executor to divide into three (3) equal parts and to transfer and pay over said three (3) equal parts and I so give, devise and bequeath the same as follows: ... (b) One (1) of said equal parts to Manchester Memorial Hospital, a hospital corporation organized and existing under the laws of the State of Connecticut and located in said Manchester, to be held as a permanent fund in memory of my husband, Philip Cheney, with power of investment and reinvestment, the income only to be used and applied for the benefit of said Hospital in such manner as the Trustees of said Hospital may in their discretion determine." Income unrestricted	The Last Will and Testament of Helen Campbell Cheney dated June 29, 1960		Request cy pres relief and transfer to the new Foundation
17-17	Albert (Herbert) Dewey	$1,498	$64,773	Unknown	There is no original or specific documentation of the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Albert Dewey at the Manchester probate court, but the Will does not include this gift; the Will indicates that Mr. Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Albert or Herbert Dewey; the Hospital believes it is the Albert Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee reference an $8,000 bequest from Albert T. Dewey that will be memorialized with a plaque in the Vestibule on the Second Floor East Building (244) as the "Gift of Albert T. and Jane N. Dewey". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-18	Jane (June) Dewey	$936	$40,482	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Jane Dewey at the Manchester probate court, but it does not include this gift; the Will indicates that Jane Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Jane or June; the Hospital believes it is the Jane Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee note a $5,000 bequest from Jane N. Dewey that will be memorialized with a plaque in the Nurses' Lounge in the Surgical Suite "In memory of Hilma N. Dillon and Emily D. Coburn". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation
17-19	The Loren Gardner Fund	$25,000	$71,576	Bequest under Article FIFTH of the Last Will and Testament of Ella C. Livermore dated October 12, 1929	Bequest of "twenty five thousand dollars ($25,000) to the Manchester Memorial Hospital, a corporation specially chartered by the State of Connecticut, located at South Manchester in said State, in memory of my father, Loren Gardner, to be held by said Hospital as a fund to be known as The Loren Gardner Fund, the income therefrom to be used for the proper uses of the Hospital. I request, but do not make it a condition, that the income, or so much as may be necessary, be applied to the maintenance of a free bed in said Hospital for poor patients." Income unrestricted with a request that it be used for free care	The Last Will and Testament of Ella C. Livermore dated October 12, 1929	Note: The Hospital has historically classified and reported this fund as restricted for free care, and it reported this as a free bed fund to the Office of the Attorney General for inclusion in the 1990 Report of the Attorney General. The donor did not, however, impose that as a binding condition. This income from this endowment fund is thus unrestricted, and the fund has been reclassified.	Request cy pres relief and transfer to the new Foundation
17-20	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,080	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 6/28/06 of portion of devise of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated Novermber 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 17-20 and 17-21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 17-83.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-21	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,080	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 7/26/06 of portion of devise of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated Novermber 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 17-20 and 17-21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 17-83.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment: Unrestricted Income Funds		$1,130,638	$9,609,344					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Free Bed Funds (Endowment Restricted for Free Care)							
17-22	Drake Fund	$90,500	$176,671	Devise under Article EIGHTH (c)(2) of the Last Will and Testament of Edith Drake Quimby dated September 7, 1949 with Codicil dated October 4, 1950	Upon the deaths of the life beneficiaries and the payment of specific bequests, Article EIGHTH (c) directs that the Trustees divide the balance of the funds: "into ten(10) equal parts and I give, devise and bequeath said parts as follows:... " (2) Two (2) of said parts to the Manchester Public Hospital, of Manchester, Connecticut, in memory of my father and mother, Levi Drake and Julia Pease Drake, the income therefrom to be used to support a bed in said hospital. It is my wish that said fund shall be known as the "Drake Bed Fund" and I request that the nomination to this bed be vested in the governing body of the Congregational Church in North Manchester, Connecticut, of which my parents were members for many years." Income restricted for free care	The Last Will and Testament of Edith Drake Quimby dated September 7, 1949; and Codicil dated October 4, 1950	Note: MMH has an active contact at the Congregational Church, which is the nominator for this fund.	Request cy pres relief and transfer to the new Foundation
17-23	The Mattie Hills Preston Free Bed Endowment	$8,000	$38,494	Bequest under Article FIFTH (a) of the Last Will and Testament of Janes M. Preston dated April 3, 1924	Bequest of "Eight Thousand ($8,000) Dollars, the same to be held by said Hospital in trust and the income thereof applied for the maintenance of a free bed, such endowment to be known as "The Mattie Hills Preston Free Bed Endowment." Income restricted for free care	The Last Will and Testament of Janes M. Preston dated April 3, 1924	Note: As stated in the Will and in the 1990 Report of the Attorney General, Article FIFTH (d) of the Will creates a second $8,000 bed fund in the name of Janes Preston if there is sufficient money. The Hospital's records do not reflect that this second bed fund was established or what happened to the second bequest.	Request cy pres relief and transfer to the new Foundation
17-24	F. O. Boynton	$923	$6,362	Devise under Last Will and Testament of F.O. Boynton (date and location unknown)	Devise of the residuary estate as follows: "I give and bequeath to the Manchester Memorial Hospital of Manchester, Connecticut,...all the rest, residue and remainder of my estate, to be held as a separate and permanent fund and the income therefrom to be used for the general purposes of the hospital with special reference to the furnishing of hospital facilities to persons then not able to pay for the service so rendered." Income restricted for free care	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995 with supporting reconciliation of funds as of 9/30/1995; excerpt from the 1990 Report of the Attorney General; and undated Exhibit A to Report to Finance Committee		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-25	Erna W. Loomis	$196,394	$330,524	(1) Bequest under ARTICLE V, paragraph L. of the Last Will and Testament of Erna W. Loomis dated July 20, 1992; and (2) Devise of a share in the residuary estate under ARTICLE V, paragraph R.4. of said Will	Erna W. Loomis left two testamentary gifts to Manchester Memorial Hospital, both of which were endowment restricted for the same purpose: Bequest under ARTICLE V, paragraph L.of "TWENTY-FIVE THOUSAND ($25,000) DOLLARS to MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, to be held in trust, the income only to be included in any program providing for the payment of anyone's expenses who cannot otherwise afford the same." Devise under ARTICLE V, paragraph R.: "All of my property thereafter remaining is to be divided into the following four (4) equal parts: ... 4. The fourth of said parts is to be added to my bequest to MANCHESTER MEMORIAL HOSPITAL, under Article V, Paragraph L of this Will and held and administered in accordance with its terms." Income restricted for free care	The Last Will and Testament of Erna W. Loomis dated July 20, 1992		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-26	Elsie Cheney Disher (Sophie H. Cheney)	$151,579	$415,675	Gift of an interest in the remainder of a trust created by Elsie C. Disher upon termination of the trust (date of trust unknown.)	The Trust provided as follows: "The remainder in equal shares to the Manchester Memorial Hospital of Manchester, Connecticut, and to _____. The gift to the Manchester Memorial Hospital is to be held as a permanent fund, in memory of my mother, the income thereof to be used so far as is necessary for the support of a private room in said Hospital, to be known as the "Sophie H. Cheney Room", said room in the discretion of the Hospital authorities to be used for the benefit of worthy cases of special need. Any balance of the income not necessary for the foregoing purpose shall be used by the Hospital authorities for the general purposes of the Hospital. I request that said authorities use a portion of the income for the erection of a suitable table in said room to be inscribed with an appropriate reference to my said mother and to her general benefactions to the community." Income restricted for free care	Excerpt from Trust Agreement of Elsie C. Disher.	Note: The Hospital has only a copy of an excerpt from the Trust agreement, which was an inter vivos trust. The Hospital has a copy of Mrs. Disher's Last Will and Testament dated May 11, 1923; that included a contingent unrestricted gift to the Hospital but did not include this trust provision. Mrs. Disher died in 1923.	Request cy pres relief only for funds, if any, not used by the Hospital
17-27	Sanford Keeney	$10,344	$154,034	Devise under Article 7th.of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income restricted for free care as to this part of the gift; see also Fund 17-13	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that during her lifetime Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 17-27. The balance of her testamentary gift is reported at Fund 17-13.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$457,740	$1,121,760					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Endowment Restricted to Purposes Other Than Free Care								
17-28	Thomas D. Trotter Memorial Fund	$500	$5,476	Bequest under ITEM VII of the Last Will and Testament of Thomas D. Trotter dated January 20, 1951	Bequest to Manchester Memorial Hospital of "the sum of Five Hundred (500) Dollars to be known as the Thomas D. Trotter Memorial Fund, and I direct that only the income from this fund is to be used, in the absolute and uncontrolled discretion of the supervisor of said hospital, in some way for the benefit of the children patients." Income restricted to benefit pediatric patients	The Last Will and Testament of Thomas D. Trotter dated January 20, 1951		Request cy pres relief and transfer to the new Foundation
17-29	William and Rebecca J. Wright Fund	$6,124	$65,567	Devise under ARTICLE IV of the Last Will and Testament of Rebecca J. Wright dated May 26, 1948	Devise of a share in the residuary estate as follows: "ARTICLE IV: ....In the event my said brother should die before me, I direct my Executor, without the requirement of setting up the Trust, to distribute the funds designated for the Trust directly to the remainder men thereof as hereinafter set forth. I direct my Trustee to divide all funds in its hands into three (3) equal shares and I direct my Trustee to pay over one (1) of said shares to The Manchester Memorial Hospital of Manchester, Connecticut, and that said share shall be kept intact as an endowment fund and that the income therefrom shall be used in the fight again Cancer, and that said share or fund shall be known as the William and Rebecca J. Wright Fund." Income restricted for cancer	The Last Will and Testament of Rebecca J. Wright dated May 26, 1948		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purposes Other Than Free Care		$6,624	$71,043					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Special Purpose Funds								
17-30	Fannie P. Fish	$260,000	$437,544	Devise under Article TENTH: (c) of the Last Will and Testament of Fannie P. Fish dated May 8, 1967	Devise of a share in the residuary estate as follows: "TENTH: I direct my Executor hereinafter named to divide all the rest, residue and remainder of my property, real and mixed, of whatsoever nature and wheresoever situate including but not limited to all property to which I am entitled in law or in equity, and all property over which I have any power of disposition or appointment at the time of my death into three (3) parts of equal net value and:... (c) To pay over one (1) of said parts to THE MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be its absolutely, PROVIDED, HOWEVER, that this bequest shall be restricted to the use of income only by the Board of Trustees or other governing body for the benefit of the Pediatric Unit at the hospital in any manner it deems appropriate for a period of ten (10) years from the date of my death. After ten (10) years from the date of my death this bequest shall be unrestricted and the Board of Trustees or other governing body of THE MANCHESTER MEMORIAL HOSPITAL may use and expend both income and principal for the benefit of the Pediatric Unit at the hospital in the manner it deems appropriate." This fund is now fully expendable for the benefit of the Pediatric Unit, the Testatrix having died in 1981.	The Last Will and Testament of Fannie P. Fish dated May 8, 1967	Note: Fannie P. Fish died in 1981, and this fund became temporarily restricted (fully expendable) for the Pediatric Unit in 1991.	Request cy pres relief only for funds, if any, not used by the Hospital
Subtotal: Special Purpose Funds		$260,000	$437,544					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Unrestricted Funds								
17-31	Pearl Sheekey	$34,368	$34,368	Devise under Article NINTH of the Last Will and Testament of Pearl Sheekey dated August 8, 1968	Devise of "All the rest and residue of my Estate of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of myself and my late husband, James H. Sheekey to be used for the general purposes of said Hospital. Unrestricted	The Last Will and Testament of Pearl Sheekey dated August 8, 1968	Note: This fund has been held and maintained by the Hospital as if it were an outside trust, but it is not subject to any such donor-imposed restriction.	Request cy pres relief only for funds, if any, not used by the Hospital
Subtotal: Unrestricted Funds		$34,368	$34,368					
Miscellaneous Funds								
17-32	Interests in the Estate of Raymond F. Damato	Unknown at this time	Unknown at this time	(1) Devise under Article SEVENTH D. of the Last Will and Testament of Raymond F. Damato dated July 7, 2009, with Codicils dated April 10, 2010, and February 11, 2011; and (2) bequests of trust termination shares under Article SIXTH of the Will.	Devise of 20% of the residuary estate "to Manchester Memorial Hospital, of Manchester, Connecticut.....Except as set forth in the individual bequests above, the bequests subject to this Paragraph shall be unrestrcied in purpose and left to the discretion of the governing board of each of the respective charitable organizations. Article SIXTH provides that, upon the termination of each of the eleven trusts created under that Article, "...the Trustee shal distribute the then remaining Trust of said deceased beneficiary,... absolutely and free of trust, to those beneficiaries and in the respective percentages set forth in Article Seventh of this my last Will and Testament. Unrestricted	The Last Will and Testament of Raymond F. Damato dated July 7, 2009,Codicil dated April 10, 2010; and Codicil dated February 11, 2011;	Note: Mr. Damato died April 25, 2014, and his Will and Codicils were admitted to probate May 6, 2014. It is premature to estimate the values of the Hospital's interests, but the estate is known to be substantial.	Use by the Hospital in the discretion of its Board
17-33	Life Insurance Policy (Name of Insured withheld)	NA	$55,638	Life Insurance Policy with face value of $50,000 issued by National Life Insurance Company	Policy owned by the Hospital with a current cash value of $55,638 Unrestricted	Face sheet of the Policy, with the name of the insured redacted		Request cy pres relief and transfer to the new Foundation if the insured is then living
Subtotal: Miscellaneous		$0	$55,638					
Grand Total: Manchester Memorial Hospital		$1,889,370	$11,329,697					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ROCKVILLE GENERAL HOSPITAL							
Endowment: Unrestricted Income Funds								
17-34	Alice Farmer Bissell Fund	$25,000	$3,720,292	Bequest under Article Fourth of the Last Will and Testament of Arthur T. Bissell dated September 1, 1932	Bequest to the Rockville City Hospital of "the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Arthur T. Bissell dated September 1, 1932		Request cy pres relief and transfer to the new Foundation
17-35	Frances Taylor Maxwell Memorial Fund	$50,000	$83,326	Devise under Article FOURTEENTH (b) of the Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956, with Codicil dated April 9, 1959	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "FOURTENTH: All the rest, residue and remainder of my estate of every name and nature, real and personal,..., I direct my executors hereinafter named to divide into six (6) equal shares: ...(b) I give, devise and bequeath one (1) of said shares to said Hartford National Bank and Trust Company, absolutely and in fee simple, but in trust, nevertheless, ... to pay over, apply or expend for the benefit of my granddaughter VIRGINIA BELDING ..the net income thereof ...Upon the death of said VIRGINIA BELDING, I direct my said Trustee to divide the principal of said trust fund into two equal portions. One (1) such portion shall be paid over to ROCKVILLE CITY HOSPITAL, an eleemosynary corporation of Connecticut located in Rockville, the principal to be kept safely invested and known as the FRANCIS TAYLOR MAXWELL MEMORIAL FUND, and the net income only used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956; and Codicil dated April 9, 1959		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-36	Stephen Goodale and Emeret Scott Risley Fund	$89,689	$919,203	(1) Bequest under Paragraph NINTH of the Last Will and Testament of May Risley Adams dated February 26, 1944; and (2) Devise under Paragraph TWENTY-FIRST of said Will	May R. Adams left two testamentary gifts to Rockville City Hospital, both of which were endowment restricted for the same purpose as follows: Bequest under Paragraph NINTH to "THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital; together with the diploma of my late father, Stephen Goodale Risley, M.D. and my John Hamilton clock, made in Glasgow, Scotland, before 1720." Devise of the residue of the estate under Paragraph TWENTY-FIRST: "All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC., in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is estabished in paragraph Ninth of this my last will and testament. Income unrestricted	The Last Will and Testament of May Risley Adams dated February 26, 1944		Request cy pres relief and transfer to the new Foundation
17-37	United German Society Fund	$10,724	$25,706	Gift from United German Society	Excerpt from "Source and Terms of Fund Held": "Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 6)		Request cy pres relief and transfer to the new Foundation
17-38	William H. Prescott	$50,000	$661,394	Bequest under Article 13. of the Last Will and Testament of William H. Prescott dated January 17, 1908 Bequests under Paragraphs 5, 9, and 15 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Bequest as follows: "13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of fifty thousand dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick ....." Bequests under the Will of Celia E. Prescott of the remainders of three $5,000 trusts upon the deaths of the respective life beneficiaries, the remainder of each given "... to the trustees of the Rockville City Hospital, in trust, for the benefit of said hospital, that the same may be added to the endowment fund provided for in the will of my late husband, William H. Prescott, for the purpose of establishing and maintaining said proposed hospital." Income unrestricted	The Last Will and Testament of William H. Prescott dated January 17, 1908; and The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-39	William Maxwell Fund	$171,719	$437,590	Devise under Article FOURTEENTH of the Last Will and Testament of William Maxwell dated December 3, 1938, with Codicils dated December 3, 1938 and January 3, 1939; inter vivos gifts, and life insurance proceeds	Devise of share of residue of estate as follows: "FOURTEENTH: To ROCKVILLE CITY HOSPITAL in Rockville, Connecticut, I give, devise, and bequeath four of said equal [one hundred] parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of William Maxwell dated December 3, 1938; Codicil dated December 3, 1938; Codicl dated January 3, 1939; document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 3); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.		Request cy pres relief and transfer to the new Foundation
17-40	Cora Lloyd Smith Fund	$7,658	$19,143	Devise under Article SIXTH (b) of the Last Will and Testament of Cora Lloyd Smith dated May 10, 1940	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "...Upon the death of my said husband CLARENCE SMITH, I direct that said trust shall cease and terminate, and I give, devise and bequeath said trust fund remaining at said time, as follows, to wit: ... (b) The remaining one-half thereof unto The ROCKVILLE CITY HOSPITAL, INC. of said town of Vernon, to be known as the Cora Lloyd Smith Fund. I direct the trustees of said Hospital to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Cora Lloyd Smith dated May 10, 1940		Request cy pres relief and transfer to the new Foundation
17-41	Bruno E. and Maud J. Doss	$8,000	$15,192	Bequest under Article THIRD d. of the Last Will and Testament of Bruno E. Doss dated May 4, 1956, as amended by Codicil dated June 17, 1957, with additional Codicils dated October 14, 1958 and January 22, 1959	Bequest under the Codicil of "...Eight Thousand (8,000) Dollars in cash to ROCKVILLE CITY HOSPITAL, INC., in trust for the following purpose: To set up a fund to be known as BRUNO E. DOSS and MAUD J. DOSS fund; to invest and reinvest the same in its discretion and to pay over only the income therefrom, at least annually, to the ROCKVILL CITY HOSPITAL GENERAL OPERATING EXPENSE ACCOUNT." Income unrestricted (for use for operations)	The Last Will and Testament of Bruno E. Doss dated May 4, 1956; Codicil dated June 17, 1957; Second Codicil dated October 14, 1958; and Third Codicil dated January 22, 1959		Request cy pres relief and transfer to the new Foundation
17-42	Eva Noble Wood Fund	$1,000	$13,410	Bequest under Article FIFTH of the Last Will and Testament of Eva Noble Wood dated June 18, 1964	Bequest to "...the ROCKVILLE CITY HOSPITAL, INC., of said Town of Vernon, the sum of One Thousand (1,000) Dollars to be held by said Hospital and the income from said sum to be used for its general uses and purposes and said sum is to be known as the Eva Noble Wood Fund." Income unrestricted	The Last Will and Testament of Eva Noble Wood dated June 18, 1964		Request cy pres relief and transfer to the new Foundation
17-43	Maud Henry	$50,000	$167,622	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest "...to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000. to be set apart and known as the Maud Henry fund in memory of my deceased daughter Maud....The income of [this fund] is to be used for the maintenance of said Hospital..." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-44	Lenore Henry	$50,000	$148,231	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest of "...Fifty thousand dollars $50,000. to said [Rockville City] Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. Income of [this fund] is to be used for the maintenance of said Hospital...." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation
17-45	George Palmer Charter Fund	$10,000	$14,409	Bequest under Article SECOND of the Last Will and Testament of George Palmer Charter (date unknown)	Bequest "...to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital." In addition, the Hospital's records indicate it was entitled to a share of the residue as follows: "SEVENTEENTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Pages 3-4)	Note: This fund holds the bequest of $10,000. Whether the Hospital received any distribution under Article SEVENTEENTH is unknown.	Request cy pres relief and transfer to the new Foundation
17-46	Anna & Albert Bilson Fund	$10,372	$14,945	Devise under Article NINTH of the Last Will and Testament of Anna M. Bilson dated October 3, 1952	Devise of a share in the residue of the estate as follows: "NINTH: All the rest, residue and remainder of my estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. .... The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc., of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Anna M. Bilson dated October 3, 1952		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-47	Alvah N. Belding Fund	$3,000	$5,764	Bequest under Paragraph 4. of the Last Will and Testament of Alvah N. Belding dated October 4, 1916	Bequest "...to the trustees of the Rockville City Hospital of Rockville, Connecticut, the sum of Three Thousand (3,000.) Dollars to be used and expended by them for the purposes indicated in the will of the late William H. Prescott regarding the establishment of a City Hospital, as they may deem most advisable." Income unrestricted	The Last Will and Testament of Alvah N. Belding dated October 4, 1916	Note: The Will of William H. Prescott created an endowment with income to be used to establish the Hospital. See Fund 17-38	Request cy pres relief and transfer to the new Foundation
17-48	Frederick W. Bradley	$2,000	$2,882	Bequest under Article FOURTEENTH of the Last Will and Testament of Frederick W. Bradley dated June 22, 1948	Bequest to "...THE ROCKVILLE CITY HOSPITAL, INC. of said Town of Vernon, the sum of Two Thousand Dollars, in memory of the donor and I direct that said sum be added to the endowment fund of said Hospital, the income thereof to be used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Frederick W. Bradley dated June 22, 1948		Request cy pres relief and transfer to the new Foundation
17-49	Ruth T. Britton Fund	$5,000	$7,204	Bequest under Article SIXTEENTH of the Last Will and Testament of Ruth Talcott Britton dated March 12, 1924, with Codicil dated January 26, 1929	Bequest "...to the Rockville Hospital, of Rockville, in the Town of Vernon, Connecticut, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees." Income unrestricted	The Last Will and Testament of Ruth Talcott Britton dated March 12, 1924; and Codicil dated January 26, 1929		Request cy pres relief and transfer to the new Foundation
17-50	William B. and Lizzie Lathrop Sprague Fund	$5,000	$7,204	Bequest under the Will of Lizzie L. Sprague dated February 5, 1921	Bequest of the residue of a testatmentary trust following the death of the life beneficiary as follows: "...at her decease said principal sum of five thousand dollars shall go to The Rockville City Hospital of Rockville, Conn, the same to be known as The Wm. B. and Lizzie Lathrop Sprague Fund." This fund is treated as endowment with income unrestricted.	The Last Will and Testament of Lizzie L. Sprague dated February 5, 1921; and minutes of February 18, 1924 meeting of the Board of Trustees of the Hospital.	Note: The Hospital has treated this as an endowment fund but the language is not clearly so restricted.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-51	George S. Doane	$5,000	$7,204	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 1); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of a George W. Doane in Springfield, but it did not include a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation
17-52	Edgar Keney (Keeney)	$500	$720	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 2); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of Edgar Keeney and that of Clara, his wife, but neither included a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-53	Rockville Chapter American Red Cross Fund	$4,000	$5,764	Gift from Rockville Chapter	The minutes of the 1920 meeting of the Board at which the gift was reported do not document any restriction on use. The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital". Income unrestricted	Minutes of the January 29, 1920 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957;	Note: The Hospital has treated this as an endowment fund but the1920 minutes do not document that restriction.	Request cy pres relief and transfer to the new Foundation
17-54	Fred Talcott Fund	$5,000	$7,204	Bequest under Article SIXTEENTH of the Last Will and Testament of Fred Talcott dated January 16, 1917	Bequest as follows: "SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital." Income unrestricted	The Last Will and Testament of Fred Talcott dated January 16, 1917	Note: See Fund 17-38 for the William Prescott Fund and its terms.	Request cy pres relief and transfer to the new Foundation
17-55	J. Alice Maxwell Fund	$6,095	$8,782	Devise under Article NINTH of the Last Will and Testament of J. Alice Maxwell dated March 28, 1941; with Codicil dated April 17, 1942	Devise to the Hospital as follows: "NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital." Income unrestricted	The Last Will and Testament of J. Alice Maxwell dated March 28, 1941; and Codicil dated April 17, 1942		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-56	William A. and Caroline E. Metcalf Fund	$7,231	$10,419	Devise under Article NINTH of the Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941	Devise of all the rest, residue and remainder of the estate "...to the Trustees of the Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, ...in trust, nevertheless, to hold, invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said Trust shall be known as the William A. and Caroline E. Metcalf Fund." Income unrestricted	The Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941		Request cy pres relief and transfer to the new Foundation
17-57	E. Stevens Henry	$1,742,007	$2,692,448	Article Fourteenth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Devise of the residue of a testamentary trust following the death of the last surviving life beneficiary as follows: "Fourteenth: I give and bequeath One hundred thousand dollars - $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry ... If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly ... Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever. Unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: The Hospital has received differing advice about the nature of this fund from outside counsels; one advised the Hospital that this fund is totally unrestricted, and another advised that it is endowment with income only to be spent. Although it is listed in this category, the Hospital believes this Fund is totally unrestricted and fully expendable.	Request cy pres relief only for funds, if any, not used by the Hospital
Subtotal: Endowment: Unrestricted Income Funds		$2,318,995	$8,996,058					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Free Bed Funds (Endowment Restricted for Free Care)								
17-58	Trumbull Chapter DAR	$157,268	$219,459	Gift of a free bed fund from the Sabra Trumbull Chapter of the Daughters of the American Revolution	Gift from the Sabra Trumbull Chapter of the D.A.R. Althugh the early history of the fund is cloudy, it appears that the fund was started at a bank in 1919, and by 1921 it had reached $5,000. In December 1954, the Advisory Board of the Chapter adopted resolutions governing the use of the bed fund summarized as follows: Income from the fund was to be used for free care with preference given to Chapter members, and, if on January 1 of a year, any income from the prior year remained on hand, it could be used for "deserving and needy people," with any unused income added to principal. The Advisory Board of the Chapter had to right to designate use of the fund. The Chapter subsequently dissolved, and by letter to the Hospital's Board of Trustees dated May 29,1962, Mrs. Donald Fisk of the Chapter advised the Hospital of the dissolution of the Chapter. The letter stated that the bank would continue to maintain the fund "with the discretion in you, as trustees, to choose beneficiaries. The former members of the Sabra Trumbull Chapter will appreciate any preference which you may choose to give to them or to other D.A.R. members as beneficiaries of this fund." Income restricted to free care, with a request to consider use for former members of the Chapter or other members of the D.A.R.	Resolution of the Board of Advisors of the Sabra Trumbull Chapter of the Daughters of the American Revolution dated December 4, 1954; letter dated May 29, 1962 from Mrs. Donald C. Fisk to the Board of Trustees, Rockville City Hospital		Request cy pres relief and transfer to the new Foundation
17-59	Celia E. Prescott Fund holding (two bed funds): 1. Francis and Eliza Porter Keeney Bed Fund (originally $10,000); and 2. Francis Keeney Prescott Bed Fund (originally $5,000)	$15,000	$28,404	Bequests under Paragraph 34 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Two bequests to establish free bed funds as follows: 34. I give to the trustees of the said Rockville City Hospital for the benefit of the same, the sum of Ten Thusand (10,000.) Dollars, for the establishment of a free bed in honor of my late father and mother, Francis and Eliza Porter Keeney, and I request that in the use of the same preference be given, if occasion arises, to any of the descendants of the Keeney family....I also give to the trustees of the said hospital, for the benefit of the same, the sum of Five Thousand (5,000.) Dollars, for the establishment of a free bed in loving memory of my late son, Francis Keeney Prescott. Income restricted to free care, with preference for descendants of the Keeney family members for the Francis and Eliza Porter Keeney Bed Fund	The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-60	Charles Phelps Free Bed Fund	$10,000	$15,383	Inter Vivos Gift from Elsie S. Phelps	Inter vivos gift from Elsie S. Phelps to establish a free bed fund in honor of her husband to be known as the Charles Phelps Free Bed Fund. Per the records of the Hospital, the terms are as follows: "Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary. Terms of Gift: 1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide. 2. For the general use and benefit of the residents of the City of Rockville. The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers or sale, investment and reinvestment." Income restricted to free care, first for members of Elsie Phelps's household staff and their families and then for residents of Rockville	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 3)		Request cy pres relief and transfer to the new Foundation
17-61	Winchell-Foster	$15,000	$22,083	Bequest under ARTICLE THIRD (i) of the Last Will and Testament of Minnie Foster Riley	Bequest of "The sum of Fifteen Thousand ($15000) Dollars to the Rockville City Hospital of Rockville, Connecticut, as a permanent fund to be known as the "Winchell-Foster Free Bed Fund" in memory of my grandparents, Cyrus and Hester Winchell, and my parents, Wilbur and Mary Edna Foster, and which sum shall be held and invested and reinvested as the governing body of said Hospital shall, in its sole discretion deem best, and the income from which shall be used for the maintenance of a free bed in said Hospital." Income restricted for free care	Letter of unclear date (July 31, 19??) from The First National Bank of Denver to the Hospital with the extract from the Will.		Request cy pres relief and transfer to the new Foundation
17-62	Betsey C. Tucker	$2,000	$3,346	Bequest under Article SECOND of the Last Will and Testament of Betsey C. Tucker dated June 21, 1949	Bequest "to the Rockville City Hospital, of Rockville, Connecticut, Two Thousand (2000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital." Income restricted for free care	The Last Will and Testament of Betsey C. Tucker dated June 21, 1949		Request cy pres relief and transfer to the new Foundation
17-63	Anna Shelton Whitlock	$20,120	$27,766	Devise under Article 2. of the Last Will and Testament of Florence R. Whitlock dated August 28, 1929	Upon the death of the life beneficiary of the residuary trust, the remainder of the residue was ro be divided into ten (10) equal parts, to be "disposed of as follows:... The remaining Four-tenths (4/10th) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock." Income restricted for free care	The Last Will and Testament of Florence R. Whitlock dated August 28, 1929		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-64	Elsie Sykes Phelps Free Bed Fund	$5,975	$18,692	Bequest under Article IV (c) of the Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955	Bequest "To the ROCKVILLE CITY HOSPITAL, of said Rockville, founded by the late William H. Prescott of said Rockville, fifty (50) shares of the capital stock of The Travelers Insurance Company, and I direct that the Trustees of said Hospital add the same to the permanent endowment of a free bed for said Rockville City Hospital, such gift to be called the "Elsie Sykes Phelps Free Bed Fund". Income restricted for free care	The Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955		Request cy pres relief and transfer to the new Foundation
17-65	John and Martha Kress Fund	$500	$2,651	Bequest under Article Fourth of the Last Will and Testament of Martha M. Kress dated April 3, 1918	Bequest of "...the sum of Five Hundred Dollars to the Rockville City Hospital to be used for the purpose of equipping, furnishing and maintaining a room in [the] Hospital to be known and called the "John and Martha Kress room." Income restricted for free care	The Last Will and Testament of Martha M. Kress dated April 3, 1918	Note: The Hospital has historically classified this as a free bed fund, but the language of the bequest is not clear on this point.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$225,863	$337,784					
Endowment Restricted to Purpose Other Than Free Care								
17-66	Julia and Percy Baker Family Memorial Fund	$145,770	$206,693	Devise under ARTICLE III (a) of the Last Will and Testament of Percy W. Baker dated June 22, 1990, with Codicils dated April 26, 1995 and May 16, 1997	Devise of a share in the residuary estate as follows: "Residue. All the rest, residue and remainder of my property, real and personal, of whatever nature and wherever situated, I give, devise and bequest as follows: (a) twenty (20) per cent to be held in trust to establish a fund known as the Julia and Percy Baker Family Memorial Fund. Said fund is to be used for the upkeep and physical maintenance of the Rockville General Hospital, Rockville, Connecticut. The physical maintenance of the Hospital by said fund is defined to include items such as painting, roof repairs, furnace repairs or replacement carpet repairs or replacement, or any other repairs or replacement of existing fixtures so as to keep the Hospital in good physical condition. The intent is that the principal of the fund so established and known as the Julia and Percy Baker Family Memorial Fund not be invaded. Only interest or other income generated by the Fund shall be used for purposes of physical maintenance, and the corpus of said fund is not to be invaded by the Trustee." Income for the upkeep and physical maintenance of the Hospital	The Last Will and Testament of Percy W. Baker dated June 22, 1990; First Codicil dated April 26, 1995; and Second Codicil dated May 16, 1997		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-67	Faith S. Schortmann Fund	$132,820	$177,300	(1) Bequest under ARTICLE VI of the Last Will and Testament of Faith S. Schortmann dated November 21, 1990; and (2) Devise of a share in the residuary estate under ARTICLE VIII A of said Will.	Bequest to ROCKVILLE GENERAL HOSPITAL of "the proceeds of all my investments with the IDS Financial Services, Inc., and its related companies, to be held as a separate fund known as the FAITH S. SCHORTMANN FUND. Said Fund shall be restricted, and the Board of Trustees or other governing body of said ROCKVILLE GENERAL HOSPITAL, INC., shall invest and reinvest such Fund in any manner it deems appropriate, but shall use or expend only the income therefrom (without invasion of the principal of said Fund) for such purposes directly related to the operation and/or improvement of the maternity and nursery facilities of said ROCKVILLE GENERAL HOSPITAL, INC., in whatever manner it deems appropriate." Devise of "FORTY-FIVE PERCENT (45%) of my said residuary estate to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be added to and become a part of the FAITH S. SCHORTMANN FUND, to be used and expended in accordance with the terms of Article VI of this, my Last Will and Testament." Income for the operation or improvement of the maternity and nursery facilities of the Hospital.	The Last Will and Testament of Faith S. Schortmann dated November 21, 1990		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purpose Other Than Free Care		$278,590	$383,993					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Unrestricted Funds								
17-68	Swindells Fund	$74,473	$107,308	Gifts from the F.W. Swindells Charitable Foundation, which was established under Article Sixth of the Last Will and Testament of Frederick W. Swindells dated October 15, 1930	The income from the Foundation (Trust) established under the Will, is to be paid "... to charitable corporations or societies incorporated for the relief of sick and suffering poor children and/or for the sick, suffering and indigent, aged men and women, and/or for the support of public and charitable hospitals....The ultimate beneficiaries of this charity shall be poor and suffering individuals." Available documentation supports that this fund is fully expendable.	The Last Will and Testament of Frederick W. Swindells dated October 15, 1930; Letters dated October 24, 1933, from The Hartford National Bank and Trust Company and The Travelers Bank and Trust Company, Trustees, transmitting two $500 checks (unrestricted); Minutes of January 27, 1936 meeting of the Board of Trustees documenting receipt of $500; Minutes of January 21, 1941 meeting of the Board of Trustees documenting receipt of $500; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 5)	Note: In an effort to obtain additional information, the Hospital spoke with Kate Kirkheart of the Swindells Charitable Foundation at the Bank of America; although the Bank has old some correspondence related to donations, it declined to release copies of the correspondence or a statement of gifts.	Request cy pres relief only for funds, if any, not used by the Hospital
17-69	Harriet K. Maxwell Fund	$5,000	$15,338	Bequest under Article Third of the Will of Harriet K. Maxwell	Bequest "...unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)". Unrestricted	Minutes of the January 20, 1953 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 2)	Note: A Harriet K. Maxwell died in 1996 in Arizona, but her Will does not include this gift, which is believed either to have come from the Will of a different member of the family or have been incorrectly designated in the old Board records as a bequest. A May 11, 1998 letter from William W. Graulty concerning gifts from the Harriet K. Maxwell Foundation also does not include any information about this fund.	
17-70	Robert Maxwell Fund	$100,000	$144,090	Bequest under Article First of the Last Will and Testament of Robert Maxwell dated November 21, 1919	Bequest to "...my Executors hereinafter named, or the survivors or survivor of them, the sum of One hundred thousand dollars ($100,000.), to be devoted by them to the establishment and maintenance of a suitable building or buildings, grounds and equipment in the City of Rockville, State of Connecticut, where the residents of the City of Rockville and vicinity may, without charge and without regard to race or religion, obtain healthful exercise, recreation, amusement and instruction, or, in the discretion of my Executors, the said principal sum or the income thereof, or both, to be devoted by them in such other manner as they deem suitable for the benefit of the said residents of Rockville and vicinity." Unrestricted	The Last Will and Testament of Robert Maxwell dated November 21, 1919		Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-71	F. Maxwell Memorial	$283,919	$1,172,965	Bequest under Article FIRST of the Codicil dated Novermber 19, 1941; and Devise under Article THIRTEENTH of the Last Will and Testament of Francis T. Maxwell dated May 15, 1940	Bequest to Rockville City Hospital of "the sum of One hundred thousand dollars ($100,000)." Devise of a share of trust assets upon termination of various testamentary trusts if no issue of the Testator is living at the time of termination as follows: "THIRTEENTH: All the rest, residue and remainder of my property, real and person, of every kind, nature and description and wheresoever situated, ... I give, devise, bequeath and appoint to my TRUSTEES.... ..(e) In the event that, upon the termination of any of said trusts, there should be no issue of mine then living, then, and in such event, I direct that the capital of such trust shall be divided into two equal parts, one of which parts I give, devise and bequeath to ROCKVILLE CITY HOSPITAL and the other to HARTFORD HOSPITAL." Unrestricted	The Last Will and Testament of Francis T. Maxwell dated May 15, 1940; and Codicil dated November 13, 1940		Request cy pres relief only for funds, if any, not used by the Hospital
17-72	Memorial Funds	$328,454	$1,285,378	Unknown	This fund holds on a consolidated basis many gifts contributed to the Hospital over the years from many sources. It has been reported as unrestricted endowment for many years. The creation of this fund is referenced in the January 20,1953 Minutes of the Board of Trustees of the Hospital. This fund is believed to be totally unrestricted as to income and principal.	Minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital; and January 24, 1968 letter from Attorney Donald B. Caldwell to Robert C. Hector of CHEFA		Request cy pres relief only for funds, if any, not used by the Hospital
17-73	Mary E. Snyder	$1,621	$2,123	Devise under Paragraph SIXTH(hh) of the Last Will and Testament of Mary E. Snyder dated My 20, 1955	Devise of a share in the residuary estate as follows: "SIXTH: All the rest, residue and remainder of all my property, both real and person, of whatsoever the same may consist or wheresoever it may be situated, I direct be divided into thirty-five equal shares and distributed as follows, to wit:... (hh) one equal share to the ROCKVILLE CITY HOSPITAL, INC. of said Rockville, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes." Unrestricted	The Last Will and Testament of Mary E. Snyder dated May 20, 1955		Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-74	Charles F. Batz	$4,000	$5,962	Inter Vivos Gift from Emma Batz for her brother, Charles F. Batz	Inter vivos gift of $4,000 Unrestricted	Correspondence between the Hospital and Emma Batz in 1993 and 1994; and the Last Will and Testament of Charles F. Batz dated November 2, 1992.	Note: ARTICLE FIVE of Charles Batz's Last Will and Testament dated November 2, 1992, left the residue of his estate outright to his sister, Emma, and, if she did not survive him, one-fourth of the residue to the Hospital outright. Emma did survive, so the Hospital was not entitled to a portion of the Estate, but Emma Batz made a $4,000 gift to the Hospital in his memory. The correspondence documenting the gift incorrectly says or suggests that this gift was a bequest from the Estate.	Request cy pres relief only for funds, if any, not used by the Hospital
17-75	Francis J. Gregory	$122,965	$34,268	Devise under Article FOURTH of the Last Will and Testament of Francis J. Gregory dated March 16, 1979	Devise of a share of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my estate, wherever it may be found, shall be distributed equally among the following [six organizations]: ...Rockville General Hospital, Rockville, Connecticut,..." Unrestricted	The Last Will and Testament of Francis J. Gregory dated March 16, 1979		Request cy pres relief only for funds, if any, not used by the Hospital
17-76	John A. Duell	$5,000	$7,453	Bequest under Article THIRD of the Last Will and Testament of John A. Duell dated September 14, 1988	Bequest to "ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut, the sum of FIVE THOUSAND ($5,000) DOLLARS, for its general use and purpose." Unrestricted	The Last Will and Testament of John A. Duell dated September 14, 1988		Request cy pres relief only for funds, if any, not used by the Hospital
17-77	Edna O. Rider	$10,000	$14,905	Bequest under Article THIRD A. of the Last Will and Testament of Edna O. Rider dated April 1, 1982	Bequest as follows: "THIRD: I give, devise and bequeath all the rest, residue and remainder of the property which I may own at the time of my death, real, personal and mixed, of whatsoever nature and wheresoever situated, as follows: A. The sum of Ten Thousand ($10,000.00) Dollars to the ROCKVILLE GENERAL HOSPITAL of Rockville, Connectiuct to be used and expended for the benefit of such hospital in any manner it deems appropriate." Unrestricted	The Last Will and Testament of Edna O. Rider dated April 1, 1982		Request cy pres relief only for funds, if any, not used by the Hospital
17-78	Barbara J. Sadrozinski	$20,739	$30,465	Devise under Article THIRD B. of the Last Will and Testament of Barbara J. Sadrozinski dated January 22, 1993.	Devise of a share of the residuary estate as follows: "THIRD I give, devise and bequeath all the rest, residue and remainder of my proprty, both real and personal, of which I shall die seized and possessed, wherever situated, as follows:...B. Twenty (20%) percent thereof to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be its absolutely and forever." Unrestricted	The Last Willl and Testament of Barbara J. Sadrozinski dated January 22, 1993.		Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Subtotal: Unrestricted Funds		$956,171	$2,820,255					
Miscellaneous Funds								
17-79	$9,603.46 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$9,603.46 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die	Two-Life Survivor Charitable Gift Annuity Agreement dated December 20, 1993 (with names redacted)		Request cy pres relief and transfer to the new Foundation if an annuitant is then living
17-80	$10,000 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$10,000 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die	Two-Life Survivor Charitable Gift Annuity Agreement dated November 3, 1994 (with names redacted)		Request cy pres relief and transfer to the new Foundation if an annuitant is then living
Subtotal: Miscellaneous		$0	$0					
Grand Total: Rockville General Hospital		$3,779,619	$12,538,090					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.							
	Endowment for Benefit of MMH: Unrestricted Income							
17-81	Hazel Burgess	$113,624	$113,624	Devise under Article THIRD of the Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Devise of half the residue of a testamentary trust following the death of the last surviving life beneficiary as follows: "THIRD: All the rest, residue and remainder of my estate, both real and personal, of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to CONNECTICUT BANK AND TRUST COMPANY, IN TRUST NEVERTHELESS, for the following uses and purposes:... (d) Upon the death of all of the beneficiaries hereunder, I direct that this Trust shall thereupon terminate, and the principal, together with any accumulation of income, be paid equally to the Board of Trustees of South Methodist Chruch and the Trustees of Manchester Memorial Hospital, both of Manchester, Connecticut, to be safely invested by each, and the income only therefrom to be used for the general uses and purposes of said Church and Hospital." Income unrestricted	The Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
17-82	Raymond A. St. Laurent and Helen St. Laurent	$10,000	$10,000	Bequest under Article NINTH 2. of the Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Bequest of "...the sum of TEN THOUSAND ($10,000.00) DOLLARS each unto each of the following named institutions or foundations, the income only from each of said bequest to be used for the general uses and purposes of said institution or foundation, the fund for each to be in memory of RAYMOND A. ST. LAURENT and HELEN E. ST. LAURENT. ... 2. MANCHESTER MEMORIAL HOSPITAL, presently of 71 Haynes St., Manchester, Connecticut; ..." Income unrestricted	The Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
17-83	Donald G. Piper and Hazel B. Piper	$1,161,399	$1,161,399	Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30, 1990	Devise of residue of estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated November 30, 1990	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Subtotal: Endowment for Benefit of MMH: Unrestricted Income		$1,285,023	$1,285,023					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Endowment for Benefit of RGH: Restricted Income							
17-84	Harriet K. Maxwell Fund	$250,000	$250,000	Grant from the Harriet K. Maxwell Foundation dated May 11, 1998	Grant to the Hospital of $250,000 as follows: "On behalf of the Directors of the Harriet K. Maxwell Foundation, I am pleased to report that the Foundation has made a grant to Rockville Hospital in the aggregate amount of $400,000. This grant consists of two parts, namely, a grant of $250,000 to establish the Harriet K. Maxwell Fund, an endowment fund to provide for the normal maintenance and repair of the Maxwell Home and its grounds and a separate grant of $150,000 to pay for the major structural repairs to the Home which are considered essential for its preservation and continued use as an integral part of the Hospital. With regard to the $250,000 Fund, this grant is conditioned on the continued use of the Maxwell Home as a part of the Hospital; and that if the Home is not so used for a period of 24 consecutive months or if the Home is damaged or destroyed and not restored to its prior level of usefulness within a reasonable time thereafter, then the balance of the Fund shall be transferred to the George Maxwell Library of Rockville, Connecticut, to be held as an endowment fund for its general uses and purposes." Income restricted for the Maxwell House	Letter dated May 11, 1998, from Attorney William W. Graulty to Annette B. Leahy of the Hospital awarding the grant; letter of June 1, 1998, from Mr. Graulty to Ms. Leahy; letter of June 1 from Mr. Graulty to Ms. Leahy forwarding a corrected copy of the May 11, 1998 letter; and press release dated June 11, 1998	Note: This contains a gift over to the George Maxwell Library of Rockville if the Hospital no longer uses the Maxwell Home as part of the Hospital.	Gift over to the George Maxwell Library of Rockville
17-85	Majorie Risley Scholarship Fund	$32,289	$32,289	Established by gifts to the Hospital	Endowment fund restricted as follows: "The Majorie Risley Scholarship Fund is established with the following primary objective: To assist nurses with their continuing education programs. The money to be used would be for educational programs that will help the nurse maintain a high level or expertise. A second use for the money would be to bring educators to this hospital to bring educational programs to a group of nurses. The principal of the fund is to be invested with high interest in mind. The income only is to be used for the above purposes. The Director of Nurses will determine who is to receive the assistance. If she needs advice relative to who should receive assistance she will consult the committee members. The members are: George E. Risley; Bunny Whelton, Geraldine Strong and Margaret Connors, R.N." Income restricted for nursing education	Statement titled "Majorie Risley Scholarship Fund" and dated February 1, 1982		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of RGH: Restricted Income		$282,289	$282,289					
	Miscellaneous							

Fund Number	Fund Name	Value of Original Gift	Total Market Value 9/30/14	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
17-86	$10,000 One Life Charitable Gift Annuity (Name of Annuitant withheld)	NA	NA	Gift of remainder interest in annuity	$10,000 Charitable Gift Annuity; remainder to Hospital on the death of the annuitant Remainder restricted for "Enhancements to the ICU Unit at Manchester Memorial Hospital."	Gift Annuity Agreement dated December 31, 2006 (with name redacted)		Request cy pres relief and transfer to the new Foundation if the annuitant is then living
Subtotal: Miscellaneous		$0	$0					
Grand Total: ECHN Community Healthcare Foundation, Inc.		$1,567,312	$1,567,312					
GRAND TOTAL FOR ECHN		$7,236,301	$25,435,099					
ADDITIONAL INFORMATION								
17-87	Katherine Sykes Bissell	–	—	Bequest under Article SEVENTH (a) of the Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969 with two codicils	Seventh: (a) I give and bequeath the sum of Fifty Thousand Dollars ($50,000) to The Rockville General Hospital, Incorporated, of Rockville, Connecticut, in memory of my parents, Mr. and Mrs. Thomas W. Sykes, the income therefrom to be used for the general purposes of said Hospital.	Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969; Codicil dated April 13, 1970: and Codicil dated April 28, 1972	Note: During its search of probate court records for original documentation, the Hospital found this Last Will and Testament, which includes a $50,000 bequest. This bequest is not separately booked or recorded on the Hospital's records, and the Hospital has not located any other records about this bequest.	

EXHIBIT 18 – SPECIAL PURPOSE FUNDS CHART

EXHIBIT 18
ECHN: SPECIAL PURPOSE FUNDS

Notes:

1. The funds are held by Manchester Memorial Hospital ("MMH"), Rockville General Hospital ("RGH"), ECHN Community Healthcare Foundation, Inc. ("ECHN Foundation"), and Woodlake at Tolland ("Woodlake")
2. The names of the donors to various funds have been redacted.
3.The current fund balance of a given fund will generally be less than the total gifts to the fund because funds are being used on an onging basis for the specific purpose.

Fund Number	Fund Name	Fund Balance 9/30/14	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
18-1	MMH: DeQuattro Cancer Center - Avis Lloyd Tree of Life	$16,994	Donors make a contribution for a leaf, dove or boulder to be added to the Tree of Life sculpture. Contributions are used for Survivorship Navigation and other services at the Cancer Center and are disbursed quarterly.	Fund profile with list of donations; copies of 2009 and 2012 brochures	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-2	ECHN Foundation: Team Towanda Foundation	$17,017	For uninsured women over the age of 40 for mammography, breast ultrasounds, surgical consultations, and related services. The fund also provides pharmacy gift cards to purchase medical and personal care items for use after surgery or to purchase medication (Outpatient).	Fund profile with list of donations; copies of representative letters and communications with Team Towanda Foundation re gifts and uses	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-3	ECHN Foundation: Employee Care Fund	$6,848	To provide confidential emergency assistance to employees in need; employee requests are made through a chaplain to the Fund. The Fund no longer solicits (the most recent appeal was in 2009); the existence of the Fund is well-known to employees, who make unsolicited contributions to it.	Fund profile with summary information	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-4	ECHN Foundation: Breast and Cervical Cancer Program	$11,709	For outreach, education, enrollment, screening and diagnostic follow-up for underinsured women for cancer and heart disease, whether inpatient or outpatient.	Fund profile with list of donations; copy of representative fundraiser flyer from major donor (fire department) and documentation of gifts from another major donor (hospital volunteers)	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-5	MMH: Adult Ambulatory Administrative Education & Development	$6,220	To offset costs in excess of ECHN tuition reimbursement for the pursuit and completion of a Master's Degree related to the roles of Adult Ambulatory Behavioral Health Coordinator, Adult Ambulatory Behavioral Health Associate Director, or Adult Ambulatory Behavioral Health Director at Manchester Memorial Hospital. Costs may include tuition, books, supplies, travel, or any other miscellaneous expenses, including computer hardware and software.	Fund profile and list of recent gifts	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-6	MMH: Drs' Campbell and Oh Trophies	$8,998	The fund maintains the trays for the Daniel Paul Purcell MD Memorial Golf Classic tournament (now called the ECHN Mason & Purcell Golf Classic), an annual fundraising event; it pays for, among other things, the engraving of the names of the low gross winners.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-7	Woodlake: Woodlake at Tolland Wishes Program	$8,330	These funds are used to grant "wishes" for long term care residents at Woodlake (long term care facility). Wishes have included a trip to NY, limo rides, luncheon trips, and special outings. Some gifts were made for listing names (honor/memorial) in the Woodlake at Tolland 10th Anniversary Program Book.	Fund profile with list of donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-8	ECHN Foundation: Planned Giving Conferences	$3,075	Funds are used to educate the community about Planned Giving opportunities to support ECHN. Can be used to fund educational programs, materials, speaker honorariums and related expenses.	Fund profile with list of donations	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-9	MMH: Marikar Memorial Lecture	$1,555	This fund is to be used to support MMH staff education lectures in Behavioral Health.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-10	RGH: Pediatric Unit	$1,179	This fund is to be used for costs associated with pediatric services at RGH.	Fund profile with list of donations	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Fund Balance 9/30/14	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
18-11	ECHN Foundation: Van Fund	$1,017	Donations from members of the Business Alliance for Community Health to purchase a new van for ECHN.	Fund profile with list of donations; email re van	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-12	ECHN Foundation: Lifeline	$733	Funds are to be used for those patients who need Lifeline but cannot afford the monthly fee. All donations in the past have been requested the funds be used for this purpose.	Fund profile with list of donations	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-13	RGH: Risley Fund	$723	Supports educational opportunities for nursing staff.	Fund profile; this is the income from the Marjorie Risley Scholarship endowment held by the ECHN Foundation.	To the extent there are funds remaining, request cy pres relief and transfer to the
18-14	Doris Fields	$582	Funds are used to support the RGH Hospice unit as a memorial to Doris Fields.	Fund profile with list of memorial donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-15	MMH: Pediatrics	$525	This fund is to be used for costs associated with pediatric services at Manchester Memorial Hospital.	Fund profile with list of donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-16	ECHN Foundation: Prostate Cancer Support Group	$442	This fund is to be used for educational materials, the promotion of support group sessions, and costs associated with these sessions.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-17	Woodlake: Resident Council Fund	$385	This account is funded by the residents of Woodlake at Tolland. The goal is to provide the residents a mechanism for self-expression and self-determination. The Resident Council is mandated by the State of Connecticut as a part of the Residents Bill of Rights. All monies are raised by the residents for the residents and used as determined by the residents of Woodlake.	Fund profile with list of donations	Continued use by Woodlake residents
18-18	MMH: Dynacad Fund	$249	This fund is to be used to offset the costs of an Dynacad imaging system to assist with MRI breast imaging and MRI guided breast biopsies conducted throughout ECHN; initial grant from the Timken Foundation.	Fund profile with list of donations; correspondence with the Timken Foundation	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-19	MMH: Pain Management Services	$152	This fund is to be used for costs associated with pain management services at MMMH.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
18-20	Woodlake: Buy a Brick Patio Fund	$64	This fund is to be used to fund the construction of a patio at Woodlake, with each donor getting the donor's name engraved on a brick.	Fund profile with list of donations; copy of solicitation material.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
GRAND TOTAL		$86,797			

EXHIBIT 19 –TRUSTS HELD BY OUTSIDE TRUSTEES

EXHIBIT 19
ECHN: TRUSTS HELD BY OUTSIDE TRUSTEES

Note: The outside Trustee(s) will have primary responsibility for actions and decisions on the distribution of trust income/assets after ECHN ceases operations. ECHN will support, to the extent possible and to the extent consistent with the terms of a given trust, the payment of trust income to the new Foundation to be used to promote the health of the ECHN communities.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 9/30/2014	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O MANCHESTER MEMORIAL HOSPITAL						
19-1	Barton Family Trust (Trust u/w Mary K. Barton)	$ 1,303,234.00	Bank of America	"FOURTH: If my sister, ANNA H. BARTON, does not survive me, then all the rest, residue and remainder of my estate, real, personal and mixed, together with any lapsed legacies, I give, devise and bequeath unto the SHAWMUT BANK, with offices in Hartford, Connecticut, or its successors, as Trustee of a certain trust to be known as the BARTON FAMILY TRUST. I ORDER AND DIRECT my Trustee ... to pay all of the net income thereof in convenient installments at least quarter/annually to or for the benefit of, the Manchester Memorial Hospital. If the Manchester Memorial Hospital or its lawful successor is no longer in existence, or if it is not then a charitable organization within the meaning of the Internal Revenue Code, the net income shall be distributed to one or more organizations selected by the trustee, each of which is a charitable organization as defined in Sections 170(c) and 2055(a) of the Internal Revenue Code of 1986, as amended from time to time, in such proportions among such organizations as the trustee shall decide."	Last Will and Testament of Mary K. Barton dated February 1, 1993	Note: This trust directs the trustee to shift the income to one or more charitable organizations if MMH or its lawful successor is no longer in existence.
19-2	The Addison L. Clark Fund (Trust u/w Luella C. Hale)	$158,178.00	Bank of America	"ARTICLE XI. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Twenty Thousand Dollars ($20,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income derived therefrom to the TRUSTEES OF THE MANCHESTER MEMORIAL HOSPITAL, to be used for such general hospital charges and expenses as said Trustees shall deem best, said fund to be known as "THE ADDISON L. CLARK FUND." "	Last Will and Testament of of Luella C. Hale dated February 7, 1938	Note: This Will does not provide for another disposition if MMH no longer exists.
19-3	The Willie T. Morton Fund (Trust u/w Willie T. Morton)	$173,730.00	Bank of America	"ELEVENTH: If the conditions set out in the two preceding clauses shall not be met with, and said sum of One Hundred Thousand (100,000) Dollars shall not be paid to said young Men's Christian Association or used for said The Morton Library Association, then I direct that said sum of One Hundred Thousand (100,000) Dollars, with accumulated interest, shall be disposed of by my said Trustee, as follows: . . . [Sections A-C direct that $20,000 be distributed to two trusts established for other charities and$10,000 given to the residue of the estate] D. The remainder of said sum of One Hundred Thousand (100,000) Dollars, I direct shall be held by my said Trustee, and one-third of said income shall be paid to the Young Men's Christian Association of Hartford, Connecticut; one-third to the Newington Home for Crippled Children of Newington, Connecticut; and one-third to the Memorial Hospital of Manchester, Connecticut. TWELFTH: [The residary estate] I give, devise and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST, for the uses and purposes and with the powers and subject to the provisions and limitations hereinafter set out: ...C. If at my death, neither my wife nor any descendants survive me; or if at the death or remarriage of my said wife, no descendants of mine should be living, or if there should be funds in my Trustee's hands under the provisions of sub-section B above and there should be no descendants of mine living at any time, then I direct that the funds in my Trustee's hands shall be used as follows: One-third of the income therefrom shall be paid to the Young Men's Christian Association of Manchester, or to The Morton Library Association of Manchester, whichever institution may take the funds under the provision of Clauses Ninth and Tenth of this Will; One-third of said income shall be paid to the Memorial Hospital of Manchester, Connecticut; and one-third of said income shall be paid to the Newington Home for Crippled Children. If neither the Young Men's Christian Association of Manchester nor The Morton Memorial Library receive the funds under the provisions of Sections Ninth and Tenth of this Will, then I direct that one-half of said income be paid to said Memorial Hospital of Manchester, and one-half said income be paid to the Newington Home for Crippled Children. I direct that the income so held and used for charitable purposes under the provisions of this Clause Twelfth shall be known as "The Willie T. Morton Fund." THIRTEENTH provides for an alternative dispoisiton of the income interest if any organization receiving income should cease to exist.	Last Will and Testament of Willie T. Morton dated February 27, 1924	Note: The trust provides for a gift over of the income interest if MMH ceases to exist.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 9/30/2014	Current Trustee	Terms of Trust	Supporting Documents	Notes
19-4	Trust u/w Grace Robertson	$148,504.00	Bank of America	**Last Will and Testament signed August 20th, 1940.** ARTICLE VII: I give to The Manchester Trust Company, a Corporation under the laws of the State of Connecticut, and located in said town of Manchester, the sum of Forty Thousand ($40,000.00) Dollars, in trust, however, to take hold, manage, invest and reinvest, and to pay the net income therefrom to the Trustees of the Manchester Memorial Hospital, a Connecticut corporation, located in said Town of Manchester, to be used for general hospital purposes. **Codicil signed August 20th, 1940.** ARTICLE I: In case my estate does not amount to enough to pay all of the special bequests or gifts made in said will, it is my will that such special bequests and/or gifts be eliminated in the following order: . . . (g) Gift for the benefit of the Manchester Memorial Hospital, set forth in Article VII; to the end that all special bequests be paid in full with the exception of the seven gifts named in this Article and that those be paid in full, if the amount of my estate admits such payment, but if such payment cannot be made, then and in that event, so far as possible, bequests and/or gifts be paid as set forth; First to the Hospital; second to the Playgrounds; Third to the Manchester Y.M.C.A.; Fourth for Education; Fifth for Parks; Sixth to the Connecticut Humane Society; and Seventh to Thorsby Institute.	Last Will and Testament of Grace Robertson dated August 20, 1940; Codicil dated August 20, 1940; Codicil dated September 10, 1942: Codicil signed August 29, 1945; and Codicildated November 10, 1953	Note: This Will does not provide for another disposition if MMH no longer exists.
19-5	Albert L. Crowell & Maytie Case Crowell Fund (Trust u/w Maytie Case Crowell)	$181,071.00	Bank of America	SIXTH: [This Article makes provision for the perpetuation of a memorial to the Testatrix's mother, Marietta Stanley Case, in the form of an Austin organ given by her family to South Methodist Church, in Manchester, Connecticut,. After reserves for a certain purpose have been accumulated], income from the trust estate herein provided for organ purposes may be distributed from time to time to Manchester Memorial Hospital for its general purposes, but provision for distribution to said Hospital shall not prevent the trustee from again accumulating and using income for organ purposes. SEVENTH: I give and bequeath the sum of fifteen thousand (15,000) dollars IN TRUST to said The Connecticut Bank and Trust Company, and in its successors in this trust upon the following trusts: Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall pay over the net income therefrom quarterly, or oftener in its discretion, in perpetuity, to The Manchester Memorial Hospital for its general purposes, this gift to be known as the Albert L. Crowell and Maytie Case Crowell Fund. Articles NINTH, ELEVENTH, THIRTEENTH and FOURTEEN provide for contingent addiitonal gifts to the Artcle SEVENTH trust.	Last Will and Testament of Maytie Case Crowell dated May 17, 1957	Note: This Will does not provide for another disposition if MMH no longer exists.
19-6	Trust u/w Andrew Ferguson	$3,884,004.00	Bank of America	ELEVENTH: All the rest, residue and remainder of my estate of every name and nature, both real and personal, including any lapsed or void legacies and devises, I give, devise and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, absolutely and in fee simple, BUT IN TRUST, NEVERTHELESS, to be held as a permanent fund in memory of ANDREW and ANN FERGUSON, for the benefit of MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, and the net income therefrom, after the payment of all necessary expenses, including reasonable compensation to my said trustee, to be paid not less often than quarterly to said Manchester Memorial Hospital, for its general uses and purposes.	Last Will and Testament of Andrew Ferguson dated April 4, 1961	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 9/30/2014	Current Trustee	Terms of Trust	Supporting Documents	Notes
19-7	Trust u/w Gertrude H. Rogers	$3,750,800.00	Original Trustees: Phoenix State Bank and Trust Company, and Robert S. Morris, of West Hartford, Connecticut	Article FIFTH creates a trust with $100 each month paid to a life beneficiary. The balance of the net income and, after the death of the life beneficiaiary, the entire net income "shall be held, used and applied for the benefit of the Manchester Memorial Hospital, a charitable corporation located in said Manchester, for which this fund shall be held as a charitable use in perpetuity, subject to the following limitations: I direct that the net income from this fund shall be used and applied for the support and development of that department of said Hospital which shall be devoted to the medical or pathological service of that Hospital, and more specifically to its research and laboratory work, that is, any investigation towards the alleviation of illness, including payment of salaries of an adequate staff, and the installation and maintenance of proper equipment, to enable that hospital to furnish complete laboratory service of this kind to the staff of that Hospital and to the physicians of the Town of Manchester for their patients of that town, whether they are then patients of that Hospital or not. Accordingly, I direct that the net income each year shall only be disbursed to the said Hospital upon a budget for this department submitted by the Hospital to the trustees under this will and approved in writing by two competent physicians..." [The Will thereafter contains very long and detailed provisions about the physicians, the budget, and the use of funds.] My purpose in creating these limitations and conditions is to keep this fund a living force in building up the quality of medical service in that Hospital and in that community, through the establishment of highly competent technical service in research and laboratory work. If at any time the trustees of my estate shall be satisfied, after conferring with the disinterested physicians whose duty it shall then be to approve the budget as above provided, that The Manchester Memorial Hospital is not devoting said funds to the purposes for which the gift is made, or is not maintaining as adequate and competent a research and laboratory staff and department as the available income will permit, said trustees shall notify the Manchester Memorial Hospital to that effect and if the failure is not corrected within a reasonable time said trustees may terminate the right of The Manchester Memorial Hospital to receive further funds under this will and thereafter said trustees may apply the income of said fund for similar purposes at the Hartford Hospital in Hartford, Connecticut. [The section continues with the requirement that there shall be two trustees, and describes how trustees shall be appointed]. Article FIRST of the Second Codicil amends Article FIFTH but does not modify the requirement that if MMH does not use the funds as specified the trustees may terminate the right of MMH to receive further funds.	Last Will and Testament of Gertrude H. Rogers dated July 13, 1937; Codicil dated October 11, 1939; Codicil dated October 21, 1940.	Note: There is no specific gift over if MMH no longer exists as a charitable organization. The Will states that if MMH fails to use the gift as intended, the trustee may apply the income for similar purposes at Hartford Hospital.
	Subtotal: Manchester Memorial Hospital	$ 9,599,521.00				

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 9/30/2014	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O ROCKVILLE GENERAL HOSPITAL						
19-8	Emma Dillon Rockville City Hospital Fund (Trust u/w Laurence M. Dillon)	$463,082.00	Bank of America	"9. I hereby give, devise and bequeath all the rest, residue and remainder of my estate, both real and personal, of whatsoever kind or character, including lapsed legacies and devises, and wheresoever situated, to THE CONNECTICUT BANK AND TRUST COMPANY, Hartford, Connecticut, as Trustee. Said Trustee shall hold, manage and control all of the aforesaid property as a trust estate, with all the rights and powers, and subject to the limitations, hereinafter enumerated, for the following uses and purposes: . . . [Part A creates a life estate for Mr. Dillon's cousin, and Part B provides that upon the death of the cousin, or if she does not survive him], the Trustee shall divide the corpus of the trust estate into two (2) equal parts, IN TRUST, NEVERTHELESS , for the following uses and purposes: 1) One of said parts, so divided, shall be set apart for the benefit of the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, in perpetuity, and the Trustee shall pay to it, or its successors or assigns, all of the net annual income derived from its said particular fund, in annual or other convenient installments. It is my wish that said fund be named the EMMA DILLON ROCKVILLE CITY HOSPITAL FUND in memorial of my beloved mother. Said net income shall be used for such general purposes as its governing board shall deem proper, and at is discretion. 2) The remaining second part, so divided, shall be set apart for the benefit of ST. BERNARD'S SOCIETY, INC. of Rockville, Connecticut . . . . In the event any or all the net income of this trust directed to be distributed to said ST. BERNARD'S SOCIETY, INC. is not distributable to said Society for a period of fifty (50) years from the date of my death for any reason, including a disclaimer by said income beneficiary, the net income of this second part shall be distributed to the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, until fifty (50) years from the date of my death, when the remaining net corpus and accretions of said remaining second part shall be paid over absolutely to said ST. BERNARD'S SOCIETY, INC., its successors or assigns.	Last Will and Testament of Laurence M. Dillon dated February 5, 1964	Note: The Will includes the language "its successors or assigns" after naming Rockville City Hospital
19-9	The Marguerite E. Moxon and Dorothy Moxon Yost Memorial Trust	$286,000.00	Bank of America	4. Use of Trust Fund. The Trustee shall distribute not less than annually all of the net income from the Trust as follows: One-half of said income to the Trustees of the Rockville General Hospital, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of such Rockville General Hospital solely for such capital improvements as the Board of Trustees or other governing body may see fit. The remaining one-half of said income to the Union Congregational Church, now located on Union Street, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of the Union Congregational Church in any manner it deems fit.	Trust Agreement dated April 2nd, 1982 between Marguerite E. Moxon and Dorothy Moxon Yost and the Connecticut Bank and Trust Company	Note: The Trust Agreement does not provide for another disposition if MMH no longer exists.
19-10	Trust u/w William E. Barton	$1,460,611.00	Bank of America	THIRD: All the rest, residue and remainder of my estate, real, personal and mixed, and wherever the same may be situated, I give, devise and bequeath in manner and form as follows, to wit: . . . [Section a) describes a gift in trust to ST. CATHERINE CEMETERY]. b) I give, devise and bequeath all the rest, residue and remainder of my estate unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee. I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom all the net income thereof unto my two sisters, ANNA H. BARTON and MARY K. BARTON, both of the Town of South Windsor, for so long as they shall live. Upon their death, I order and direct that all of the net income thereof be paid over and distributed unto the ROCKVILLE GENERAL HOSPITAL, of Rockville, Connecticut, to be used by it as it deems fit.	Last Will and Testament of William E. Barton dated December 9, 1988	Note: The Will does not provide for another disposition if MMH no longer exists.
Subtotal: Rockville General Hospital		$2,209,693.00				
	GRAND TOTAL	$ 11,809,214.00				

EXHIBIT 20 – UNDERLYING DOCUMENTATION FOR ALL FUNDS – BULK FILE ONLY

EXHIBIT 21 – PROJECTED FINANCIALS TO DUFF & PHELPS

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

INCOME STATEMENT

	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Net Patient Revenue	$299,860,030	$307,651,030	$316,898,368	$329,155,766	$340,477,976
Operating Expenses:					
Salaries/Temporary Help	$163,703,447	$166,529,550	$169,860,141	$171,558,743	$173,274,330
Fringe Benefits	$47,412,898	$45,485,898	$47,262,475	$48,371,349	$49,204,490
Supplies	$89,203,310	$88,073,822	$90,934,983	$93,877,958	$96,909,515
Physician Fees	$12,179,000	$12,524,000	$12,899,720	$13,286,712	$13,685,313
Depreciation	$12,300,000	$12,300,000	$12,300,000	$12,300,000	$12,300,000
Interest	$3,903,398	$4,120,000	$4,120,000	$4,120,000	$4,120,000
Total Operating Expenses	$328,702,053	$329,033,271	$337,377,319	$343,514,762	$349,493,648
Other Operating Revenue	$14,453,886	$12,991,886	$12,114,886	$11,237,886	$11,237,886
Joint Venture Income	$2,139,000	$2,181,780	$2,225,416	$2,269,924	$2,315,322
Public Support	$1,712,682	$1,500,000	$1,500,000	$1,500,000	$1,500,000
Net Assets Released	$1,868,881	$1,250,000	$1,250,000	$1,250,000	$1,250,000
Grants	$2,434,043	$2,434,043	$2,434,043	$2,434,043	$2,434,043
Realized Gains	$5,585,000	$0	$0	$0	$0
Interest Income	$1,667,000	$1,550,000	$1,596,500	$1,644,395	$1,693,727
Total Other Operating Revenue	$29,860,492	$21,907,709	$21,120,845	$20,336,248	$20,430,978
Net Operating Income/(Loss)	$1,018,469	$525,468	$641,893	$5,977,251	$11,415,306
Non-Operating Exp's	($500,000)	($500,000)	($500,000)	($500,000)	($500,000)
Excess Rev's (Exp's)	$518,469	$25,468	$141,893	$5,477,251	$10,915,306
EBITDA	$16,721,867	$16,445,468	$16,561,893	$21,897,251	$27,335,306

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

CASHFLOW	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Sources:					
Depreciation	$12,300,000	$12,300,000	$12,300,000	$12,300,000	$12,300,000
Interest Expense	$3,903,398	$4,120,000	$4,120,000	$4,120,000	$4,120,000
Release of Funds	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
HITECH/MU Funds	($2,630,000)	$877,000	$877,000	$0	$0
JV Non-Cash	($336,000)	($341,040)	($346,156)	($351,348)	($356,618)
Revenue Cycle Improvement	$0	$2,100,000	$2,000,000	$0	$0
Non-Operating Exp's	($500,000)	($500,000)	($500,000)	($500,000)	($500,000)
Uses:					
Debt Service	($10,464,000)	($11,128,000)	($11,083,000)	($11,656,000)	($12,028,000)
Pension Expense	$3,300,000	$1,400,000	$900,000	$600,000	$0
Pension Funding	($3,500,000)	($5,700,000)	($6,000,000)	($10,250,000)	($11,700,000)
Capital	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)
Projected Surplus/(Lost) Cash Position	($908,133)	($346,572)	($1,090,263)	($3,760,097)	($749,312)
Cumulative Cash Position Surplus	($908,133)	($1,254,705)	($2,344,967)	($6,105,064)	($6,854,376)
COVENANTS					
Debt Service Coverage Ratio (System)	1.60	1.48	1.49	1.88	2.27
Debt Service Coverage Ratio (incl. Pensic	1.58	1.09	1.03	1.05	1.30
Days Cash on Hand (System)	79.0	78.5	75.7	71.3	73.3
Days Cash on Hand (OG)	84.5	83.9	80.6	75.4	78.2
TOTAL EBITDA for DEBT SERVICE	$16,721,867	$16,445,468	$16,561,893	$21,897,251	$27,335,306
ANNUAL DEBT	($10,464,000)	($11,128,000)	($11,083,000)	($11,656,000)	($12,028,000)
MIN EBITDA for DEBT SERVICE	$13,080,000	$13,910,000	$13,853,750	$14,570,000	$15,035,000
NET INCOME "CUSHION"	$3,641,867	$2,535,468	$2,708,143	$7,327,251	$12,300,306

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Sources:					
Net Income	$1,018,469	$525,468	$641,893	$5,977,251	$11,415,306
Add: Depreciation & Interest	$16,203,398	$16,420,000	$16,420,000	$16,420,000	$16,420,000
EBITDA	$17,221,867	$16,945,468	$17,061,893	$22,397,251	$27,835,306
Add/Less: Other Adj's	($2,466,000)	$3,135,960	$3,030,844	$148,652	$143,382
Add: Pension FAS Expense	$3,300,000	$1,400,000	$900,000	$600,000	$0
ADJ EBITDA	$18,055,867	$21,481,428	$20,992,737	$23,145,903	$27,978,688
Uses:					
Debt Service	$10,464,000	$11,128,000	$11,083,000	$11,656,000	$12,028,000
Pension Funding	$3,500,000	$5,700,000	$6,000,000	$10,250,000	$11,700,000
Capital	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Cash Surplus / (Shortfall)	($908,133)	($346,572)	($1,090,263)	($3,760,097)	($749,312)
	$18,055,867	$21,481,428	$20,992,737	$23,145,903	$27,978,688
% Used for Debt Service	58.0%	51.8%	52.8%	50.4%	43.0%
% Used for Pension	19.4%	26.5%	28.6%	44.3%	41.8%
% Used for Debt + Pension	77.3%	78.3%	81.4%	94.6%	84.8%

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Statement of Changes in Cashflow					
Changes in Operating Activities					
Excess of Revenues > Expenses	$1,018,469	$525,468	$641,893	$5,977,251	$11,415,306
Non Core Expenses	($500,000)	($500,000)	($500,000)	($500,000)	($500,000)
Depreciation and amortization	$12,300,000	$12,300,000	$12,300,000	$12,300,000	$12,300,000
Income on Joint Ventures	($2,139,000)	($2,181,780)	($2,225,416)	($2,269,924)	($2,315,322)
Pension Expense	$3,300,000	$1,400,000	$900,000	$600,000	$0
Pension Funding	($3,500,000)	($5,700,000)	($6,000,000)	($10,250,000)	($11,700,000)
Restricted Funds Released	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Receipt of HITECH Funds	($2,630,000)	$877,000	$877,000	$0	$0
A/R (Rev Cycle)	$0	$2,100,000	$2,000,000	$0	$0
Net Cash from Operating Activities	$8,849,469	$9,820,688	$8,993,477	$6,857,327	$10,199,984
Changes in Investing Activities					
Purchases of PPE	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)
Investments in New Services	$0	$0	$0	$0	$0
Distributions from Joint Ventures	$1,803,000	$1,840,740	$1,879,260	$1,918,576	$1,958,704
Net Cash from Investing Activities	($9,197,000)	($9,159,260)	($9,120,740)	($9,081,424)	($9,041,296)
Changes in Financing Activities					
Principal Payments on LT Debt	($6,560,602)	($7,008,000)	($6,963,000)	($7,536,000)	($7,908,000)
Proceeds from Borrowings	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000
Net Cash from Financing Activities	($560,602)	($1,008,000)	($963,000)	($1,536,000)	($1,908,000)
Change in Cash	($908,133)	($346,572)	($1,090,263)	($3,760,097)	($749,312)

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

INCOME STATEMENT

	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Net Patient Revenue	$299,930,000	$307,721,000	$316,969,037	$329,227,142	$340,549,709
Operating Expenses:					
Salaries/Temporary Help	$164,080,000	$166,917,400	$170,255,748	$171,958,305	$173,677,889
Fringe Benefits	$47,775,000	$45,848,000	$47,635,440	$48,755,503	$49,600,168
Supplies	$99,452,000	$98,524,670	$101,367,910	$104,296,447	$107,312,841
Physician Fees	$12,179,000	$12,524,000	$12,899,720	$13,286,712	$13,685,313
Depreciation	$12,300,000	$12,300,000	$12,300,000	$12,300,000	$12,300,000
Interest	$3,903,000	$4,120,000	$4,120,000	$4,120,000	$4,120,000
Total Operating Expenses	$339,689,000	$340,234,070	$348,578,818	$354,716,968	$360,696,211
Other Operating Revenue	$28,018,758	$26,556,758	$25,679,758	$24,802,758	$24,802,758
Joint Venture Income	$2,139,000	$2,181,780	$2,225,416	$2,269,924	$2,315,322
Public Support	$1,498,361	$1,500,000	$1,500,000	$1,500,000	$1,500,000
Net Assets Released	$1,868,881	$1,250,000	$1,250,000	$1,250,000	$1,250,000
Realized Gains	$5,585,000	$0	$0	$0	$0
Interest Income	$1,667,000	$1,550,000	$1,596,500	$1,644,395	$1,693,727
Total Other Operating Revenue	$40,777,000	$33,038,538	$32,251,674	$31,467,077	$31,561,807
Net Operating Income/(Loss)	$1,018,000	$525,468	$641,893	$5,977,251	$11,415,306
Non-Operating Exp's	($500,000)	($500,000)	($500,000)	($500,000)	($500,000)
Excess Rev's (Exp's)	$518,000	$25,468	$141,893	$5,477,251	$10,915,306
EBIDTA	$16,721,000	$16,445,468	$16,561,893	$21,897,251	$27,335,306

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

CASHFLOW	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Sources:					
Depreciation	$12,300,000	$12,300,000	$12,300,000	$12,300,000	$12,300,000
Interest Expense	$3,903,000	$4,120,000	$4,120,000	$4,120,000	$4,120,000
Release of Funds	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
HITECH/MU Funds	($2,630,000)	$877,000	$877,000	$0	$0
JV Non-Cash	($336,000)	($341,040)	($346,156)	($351,348)	($356,618)
Revenue Cycle Improvement	$0	$2,100,000	$2,000,000	$0	$0
Non-Operating Exp's	($500,000)	($500,000)	($500,000)	($500,000)	($500,000)
Uses:					
Debt Service	($10,464,000)	($11,128,000)	($11,083,000)	($11,656,000)	($12,028,000)
Pension Expense	$3,300,000	$1,400,000	$900,000	$600,000	$0
Pension Funding	($3,500,000)	($5,700,000)	($6,000,000)	($10,250,000)	($11,700,000)
Capital	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)
Projected Surplus/(Lost) Cash Position	($909,000)	($346,572)	($1,090,263)	($3,760,097)	($749,312)
Cumulative Cash Position Surplus	($909,000)	($1,255,572)	($2,345,835)	($6,105,932)	($6,855,244)
COVENANTS					
Debt Service Coverage Ratio (System)	1.60	1.48	1.49	1.88	2.27
Debt Service Coverage Ratio (incl. Pensic	1.58	1.09	1.03	1.05	1.30
Days Cash on Hand (System)	76.4	75.9	73.2	69.0	71.0
Days Cash on Hand (OG)	81.6	81.0	77.9	72.9	75.6
TOTAL EBIDTA for DEBT SERVICE	$16,721,000	$16,445,468	$16,561,893	$21,897,251	$27,335,306
ANNUAL DEBT	($10,464,000)	($11,128,000)	($11,083,000)	($11,656,000)	($12,028,000)
MIN EBIDTA for DEBT SERVICE	$13,080,000	$13,910,000	$13,853,750	$14,570,000	$15,035,000
NET INCOME "CUSHION"	$3,641,000	$2,535,468	$2,708,143	$7,327,251	$12,300,306

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Sources:					
Net Income	$1,018,000	$525,468	$641,893	$5,977,251	$11,415,306
Add: Depreciation & Interest	$16,203,000	$16,420,000	$16,420,000	$16,420,000	$16,420,000
EBIDTA	$17,221,000	$16,945,468	$17,061,893	$22,397,251	$27,835,306
Add/Less: Other Adj's	($2,466,000)	$3,135,960	$3,030,844	$148,652	$143,382
Add: Pension FAS Expense	$3,300,000	$1,400,000	$900,000	$600,000	$0
ADJ EBIDTA	$18,055,000	$21,481,428	$20,992,737	$23,145,903	$27,978,688
Uses:					
Debt Service	$10,464,000	$11,128,000	$11,083,000	$11,656,000	$12,028,000
Pension Funding	$3,500,000	$5,700,000	$6,000,000	$10,250,000	$11,700,000
Capital	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Cash Surplus / (Shortfall)	($909,000)	($346,572)	($1,090,263)	($3,760,097)	($749,312)
	$18,055,000	$21,481,428	$20,992,737	$23,145,903	$27,978,688
% Used for Debt Service	58.0%	51.8%	52.8%	50.4%	43.0%
% Used for Pension	19.4%	26.5%	28.6%	44.3%	41.8%
% Used for Debt + Pension	77.3%	78.3%	81.4%	94.6%	84.8%

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

	Unaudited FY 2013	Budget FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017
Statement of Changes in Cashflow					
Changes in Operating Activities					
Excess of Revenues > Expenses	$1,018,000	$525,468	$641,893	$5,977,251	$11,415,306
Non Core Expenses	($500,000)	($500,000)	($500,000)	($500,000)	($500,000)
Depreciation and amortization	$12,300,000	$12,300,000	$12,300,000	$12,300,000	$12,300,000
Income on Joint Ventures	($2,139,000)	($2,181,780)	($2,225,416)	($2,269,924)	($2,315,322)
Pension Expense	$3,300,000	$1,400,000	$900,000	$600,000	$0
Pension Funding	($3,500,000)	($5,700,000)	($6,000,000)	($10,250,000)	($11,700,000)
Restricted Funds Released	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Receipt of HITECH Funds	($2,630,000)	$877,000	$877,000	$0	$0
A/R (Rev Cycle)	$0	$2,100,000	$2,000,000	$0	$0
Net Cash from Operating Activities	$8,849,000	$9,820,688	$8,993,477	$6,857,327	$10,199,983
Changes in Investing Activities					
Purchases of PPE	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)
Investments in New Services	$0	$0	$0	$0	$0
Distributions from Joint Ventures	$1,803,000	$1,840,740	$1,879,260	$1,918,576	$1,958,704
Net Cash from Investing Activities	($9,197,000)	($9,159,260)	($9,120,740)	($9,081,424)	($9,041,296)
Changes in Financing Activities					
Principal Payments on LT Debt	($6,561,000)	($7,008,000)	($6,963,000)	($7,536,000)	($7,908,000)
Proceeds from Borrowings	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000
Net Cash from Financing Activities	($561,000)	($1,008,000)	($963,000)	($1,536,000)	($1,908,000)
Change in Cash	($909,000)	($346,572)	($1,090,263)	($3,760,097)	($749,312)

EXHIBIT 22 – FINANCIAL SUMMARY OF JOINT VENTURES

ECHN Joint Venture Activity

Distributions	FY 2013	FY 2012	FY 2011	FY 2010
ECHN Parent				
Ambulance Service of Manchester	1,150,000	1,050,000	1,300,000	900,000
ECHN Enterprises				
Haynes St Med Associates I	20,055	18,909	13,294	11,689
Haynes St Med Associates II	48,750	45,000	22,500	-
Evergreen Medical I	88,000	60,000	33,000	27,000
Evergreen Medical II	46,000	35,500	18,250	5,500
MMH				
GI Joint Venture	450,000	350,000	525,000	200,000
Evergreen Imaging	-	95,000	60,000	9,000
Total Distributions	**1,802,805**	**1,654,409**	**1,972,044**	**1,153,189**

Income	FY 2013	FY 2012	FY 2011	FY 2010
RGH				
Tolland Imaging	28,110	32,750	(24,939)	(5,416)
NRRON	53,165	236,091	(6,174)	321,346
ECHN Parent				
Walden BH	22,580	-	-	-
Ambulance Service of Manchester	1,426,958	1,352,486	1,120,236	1,323,714
VNHSC	-	652,809	227,662	172,080
ECHN Enterprises				
Haynes St Med Associates I	23,572	(31,257)	41,959	2,843
Haynes St Med Associates II	33,219	55,535	(48,541)	(397)

Evergreen Medical I	87,319	17,029	23,582	15,780
Evergreen Medical II	(269)	(51,479)	28,325	(34,560)
MMH				
GI Joint Venture	345,654	365,869	326,735	379,549
NRRON	53,165	236,091	(6,174)	321,345
Tolland Imaging	28,110	32,750	(24,939)	(5,416)
Medical Practice Partners	37,070	(124,968)	32,480	(335,843)
Evergreen Imaging	-	157,783	115,954	94,512
Total Income	**2,138,653**	**2,931,489**	**1,806,166**	**2,249,537**

EXHIBIT 23 – CURRENT HOSPITAL SERVICES

Attachment 19 - List of ECHN's Current Service Lines and Service Locations

As of October 24, 2014

M = Service falls under Manchester Memorial Hospital *R = Service falls under Rockville General Hospital* *J = Service provided through a joint venture affiliate* *A=Services provided through a wholly owned affiliate*	Manchester Memorial Hospital 71 Haynes Street Manchester		Rockville General Hospital 31 Union Street Vernon		1707 Boston Turnpike Coventry	11 Pinney Street Ellington	175 West Road Ellington	622 Hebron Avenue Glastonbury	43 Woodland Street Hartford	100 Haynes Street Manchester	130 Hartford Road Manchester	150 North Main Street Manchester	360 Tolland Turnpike Manchester	2400 Tamarack Avenue South Windsor	2600 Tamarack Avenue South Windsor	2800 Tamarack Avenue South Windsor	6 Fieldstone Commons Tolland	26 Shenipsit Lake Road Tolland	428 Hartford Turnpike Vernon	47 Hartford Turnpike Vernon	8 Keynote Drive Vernon
Service (by Service Line)	**IP**	**OP**	**IP**	**OP**	Outpatient Service Locations																
Behavioral Health Services																					
Adult Behavioral Health Inpatient Services	M	M[(1)]																			
Adult Behavioral Health Outpatient Services		M										M									
Adult Partial Hospitalization Program		M																			
Adolescent Inpatient Services	M	M[(1)]																			
Child and Adolescent Outpatient Services		M		R																	
Child and Adolescent Partial Hospitalization Program		M																			
Clinical Day School		M																			
Crisis Services		M		R																	
Eating Disorders Program				R										J							
Cardiac, Vascular, & Neurology Services																					
Cardiac Diagnostic Testing (i.e. Echo, EKG, etc.)	M	M	R	R																	
Cardiac Rehabilitation		M		R																	
Cardio Pulmonary Services	M	M	R	R																	
Heart Failure Clinic		M																			
Medical Cardiology	M	M	R	R																	
Medical Neurology	M	M	R	R																	
Sleep Lab		M																			
SPECT (Cardiac Nuclear Medicine)	M	M	R	R																	
Stress Lab	M	M	R	R																	
Telemetry Monitoring	M	M	R	R																	
Telestroke Services	M	M	R	R																	
Emergency Services																					
Emergency Department	M	M	R	R																	
Urgent Care																R					
General Acute Care Services																					
General Medical/Surgical Care	M	M[(1)]	R	R[(1)]																	
Medical/Surgical Intensive Care Unit (ICU)	M	M[(1)]	R	R[(1)]																	
Other Special Care Unit (SCU)	M	M[(1)]	R	R[(1)]																	
Pediatric Medical/Surgical Care[(2)]	M	M[(1)]	R	R[(1)]																	
Laboratory Services																					
Laboratory	M	M	R	R	M				M	M									M		
Phlebotomy	M	M	R	R	M		M	M	M	M	M		M	M			M		M		
Medical Imaging Services																					
Bone Density								M							R		J				
CT Scan	M	M	R	R												R	J				
Diagnostic Radiology (x-ray)	M	M	R	R				M								R	J				
Interventional Radiology	M	M	R	R																	
Mammography		M		R				M							R		J				
MRI	M	M	R	R												R	J				
Nuclear Medicine	M	M	R	R																	
PET Scan		M																			
Ultrasound	M	M	R	R											R	R	J				

Attachment 19 - List of ECHN's Current Service Lines and Service Locations

As of October 24, 2014

M = Service falls under Manchester Memorial Hospital *R = Service falls under Rockville General Hospital* *J = Service provided through a joint venture affiliate* *A=Services provided through a wholly owned affiliate*	Manchester Memorial Hospital 71 Haynes Street Manchester		Rockville General Hospital 31 Union Street Vernon		1707 Boston Turnpike Coventry	11 Pinney Street Ellington	175 West Road Ellington	622 Hebron Avenue Glastonbury	43 Woodland Street Hartford	100 Haynes Street Manchester	130 Hartford Road Manchester	150 North Main Street Manchester	360 Tolland Turnpike Manchester	2400 Tamarack Avenue South Windsor	2600 Tamarack Avenue South Windsor	2800 Tamarack Avenue South Windsor	6 Fieldstone Commons Tolland	26 Shenipsit Lake Road Tolland	428 Hartford Turnpike Vernon	47 Hartford Turnpike Vernon	8 Keynote Drive Vernon
Service (by Service Line)	**IP**	**OP**	**IP**	**OP**	Outpatient Service Locations																
Metabolic Services																					
Diabetes Management		M																			
Dialysis	M	M	R	R																	
Nutritional Services	M	M	R	R											R						
Oncology services																					
Chemotherapy	M	M																			
Oncology services	M	M	R	R						M											
Radiation Oncology										J											
Rehabilitation Services																					
Occupational Therapy	M	M	R	R												M				R	
Physical Therapy	M	M	R	R		R		M								M				R	
Speech Therapy	M	M	R	R																	
Surgical Services																					
Colorectal	M	M	R	R																	
Endoscopy	M	M	R	R										J							
General Surgery	M	M	R	R																	
Gynecology	M	M	R	R																	
Joint Replacement	M																				
Minimally Invasive	M	M	R	R																	
Ophthalmology	M	M	R	R																	
Oral and Maxofacial Surgery	M	M	R	R																	
Orthopedic	M	M	R	R																	
Otolaryngology (Ear, Nose and Throat)	M	M	R	R																	
Plastic and Reconstructive	M	M	R	R																	
Robotic	M	M																			
Spine/Neurosurgery	M	M	R	R																	
Thoracic	M	M	R	R																	
Urology	M	M	R	R																	
Vascular	M	M	R	R																	
Wound Care	M	M	R																		
Women and Infant Services																					
Breast Ultrasound	M	M	R	R											R						
Breast Ultrasound Biopsy	M	M	R	R											R						
Maternity Care Center (Prenatal Care)				R																	
Neonatal Intensive Care Unit (Level III NICU)	M																				
Obstetrics	M	M[(1)]																			
Stereotactic Breast Biopsy															R						
Other - Miscellaneous Services																					
Community Health Education		M		R												R					
Complementary and Alternative Medicine Services	M	M	R	R				M							R						
Home Care Services																					A
Hospice	M		R																		A
Long-Term Care																		A			
Occupational Medicine																M					
Short-Term Rehabilitation																		A			

(1) Patients may receive outpatient observation services on one of the designated inpatient units.

(2) Manchester Memorial Hospital and Rockville General Hospital do not have dedicated units for inpatient pediatric services. Patients age 14 years and older receive inpatient services on the adult medical/surgical units

ECHN: System Service Locations[3]

Street	Site	Town	State	Zipcode
1707 Boston Turnpike	Meadowbrook Plaza	Coventry	CT	06238
11 Pinney Street	ECHN Rehabilitation Services at the Ellington Y	Ellington	CT	06029
175 West Road	ECHN Medical Offices	Ellington	CT	06029
622 Hebron Avenue	Glastonbury Wellness Center	Glastonbury	CT	06033
43 Woodland Street	Medical Office Building at Gothic Park	Hartford	CT	06105
100 Haynes Street	John A. DeQuattro Cancer Center	Manchester	CT	06040
130 Hartford Road	Manchester Medical Offices	Manchester	CT	06040
150 North Main Street	ECHN Medical Office Building	Manchester	CT	06042
360 Tolland Turnpike	Tolland Turnpike, East Point	Manchester	CT	06040
71 Haynes Street	Manchester Memorial Hospital	Manchester	CT	06040
2400 Tamarack Avenue	Evergreen Walk	South Windsor	CT	06074
2600 Tamarack Avenue	Women's Center for Wellness	South Windsor	CT	06074
2800 Tamarack Avenue	CorpCare Occupational Health	South Windsor	CT	06074
2800 Tamarack Avenue	ECHN Medical Office Building at Evergreen Walk	South Windsor	CT	06074
2800 Tamarack Avenue	Evergreen Imaging Center	South Windsor	CT	06074
2800 Tamarack Avenue	Urgent Care at South Windsor	South Windsor	CT	06074
6 Fieldstone Commons	ECHN Medical Offices	Tolland	CT	06084
26 Shenipsit Lake Road	Woodlake at Tolland Nursing and Rehabilitation Center	Tolland	CT	06084
31 Union Street	Rockville General Hospital	Vernon	CT	06066
428 Hartford Turnpike	Hartford Turnpike	Vernon	CT	06066
47 Hartford Turnpike	The Rehab Center at Big Sky Fitness	Vernon	CT	06066
8 Keynote Drive	Visiting Nurse and Health Services of Connecticut	Vernon	CT	06066

(3) A listing of the Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) primary care and specialty care locations will be submitted in the Change of Ownership CON application for ECMPF.

As of October 24, 2014

EXHIBIT 24 – COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLANS FOR MMH AND RGH

Manchester Memorial Hospital

An affiliate of Eastern Connecticut Health Network

Community Health Needs Assessment Implementation Plan

2013

I. INTRODUCTION

Manchester Memorial Hospital (MMH), as part of the Eastern Connecticut Health Network (ECHN), dedicates millions of dollars and thousands of staff hours to activities that enhance the overall health and wellness of its 19-town service area with special focus on the unmet needs of financially disadvantaged and underserved populations.

MMH primarily serves the Connecticut towns of Manchester, South Windsor, Bolton, Coventry, Andover, Ellington, Tolland, Vernon, and Willington. Its secondary service area includes the towns of Ashford, Somers, Stafford, Union, East Hartford, East Windsor, Glastonbury, Hebron, Columbia and Mansfield. The service areas contain municipalities in Hartford, Tolland and Windham Counties.

In 2013, MMH collaborated with Rockville General Hospital, also an affiliate of ECHN, to conduct a comprehensive community health needs assessment (CHNA). The goals of the assessment were:

- To identify current and future healthcare needs in the community
- To improve and strengthen programs and services provided to address them

The CHNA process was led by an Oversight Committee that included members of the organization with established relationships with community groups and agencies.

Data collected for the CHNA included:

- Health, social, and demographic data specific to MMH's service area obtained from local public health agencies, national health associations and other data sources.
- Health behavior information collected from 1,047 residents who responded to a community survey.
- Input from 12 community stakeholders from local organizations invested in the health of underserved populations.

Once all data was collected and analyzed, the Oversight Committee identified and prioritized the service area's key health needs and developed an implementation strategy to respond to the needs.

This document details the priority health needs that were identified and the implementation plan developed to address them.

II. IDENTIFIED AREAS OF NEED

Analysis of the CHNA data identified the following areas of need:

A. Heart Disease Incidence

Heart disease remains the #1 cause of death in the state and nation. Incidence rates in the service area are similar to national rates. High blood pressure and high cholesterol were the two health conditions most reported among the CHNA survey respondents.

B. Cancer Incidence

Cancer continues to be the second leading cause of death in the MMH service area, in Connecticut, and in the United States. Incidence rate estimates for Cancer (All Sites) and Breast for the total service area are above that of the nation. Prostate and Colon & Rectum cancer rates for the Total Service Area are above both the state and the nation.

C. Diabetes Incidence

Estimated diabetes prevalence rates for 2017 show an alarming increase in the total service area, while state and national estimates remain at or near 2012 rates. An estimated 60,000 to 93,000 adults have undiagnosed diabetes.

D. Arthritis Incidence

There is a higher incidence of arthritis, chronic lower back pain, lower back pain, and neck pain in the service area when compared with national prevalence rates among individuals over the age of 18 years of age.

E. Alzheimer's disease Incidence

There is a higher incidence of Alzheimer's disease among service area residents over the age of 65 compared to national incident rate estimates.

F. Multiple Sclerosis Incidence

The incidence rate of Multiple Sclerosis is higher in the service area when compared to national figures.

G. Substance Abuse

Community stakeholders reported drug and alcohol abuse to be a serious problem in the service area.

H. Childhood Lead Screening

Fewer children in the service area are being screened for lead compared to state percentages but the percentage of children with elevated level levels in the service area remain lower than the state rate.

III. THE PRIORITY NEEDS

The Oversight Committee prioritized the CHNA's identified health needs based primarily on the size and severity of a particular need, and also took into account the hospital's ability to impact the need, and the availability of resources that exist to address it. Based on these criteria, the following health needs were given the highest priority:

- Heart Disease Incidence
- Cancer Incidence
- Diabetes Incidence
- Arthritis Incidence

IV. STRATEGIES TO ADDRESS PRIORITY NEEDS

The overall goal in addressing each priority needs is to 1. Reduce the preventable risk factors that contribute to incidence of the respective health issue and 2. Promote quality of life for those diagnosed. Each set of strategies will target the broader population with special focus on the financially disadvantaged and underserved populations.

A. Strategies to Address Heart Disease Incidence:

- Educate the public about managing lifestyle behaviors that impact diet, blood pressure, cholesterol, weight, physical activity, and stress.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area where free blood pressure, cholesterol, body fat composition analysis and educational resources will be shared.
    - Launch the "Freedom from Smoking" smoking cessation program
    - Provide nutrition counseling services
    - Offer integrative medicine programs for stress reduction
- Provide information and services to individuals diagnosed with heart disease to help them best manage their symptoms
    - Offer free "Heart Talk" community program for people living with heart failure

- Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level.

B. Strategies to Address Cancer Incidence:

- Monitor reports of newly- diagnosed cancer cases in the service area using the National Cancer Center Data Base (NCDB) to identify significant changes, trends or abnormal activity.
- Educate the public about managing lifestyle behaviors that impact cancer risks
  - Cancer Community Outreach Community will coordinate free community health educational lecture and seminar programs.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.
  - Launch the "Freedom from Smoking" smoking cessation program
- Provide free screenings in the community and access to follow-up care
- Offer comprehensive support programs for cancer survivors and caregivers
  - Oncology Nurse Navigator and Survivorship Navigators services
  - Annual Cancer Survivors Day event
  - Regular support group meetings
  - Cancer Caregiver Workshops

C. Strategies to Address Diabetes Incidence:

- Raise awareness of diabetes preventable risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.

- Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared.

- Offer Diabetes Self Management Program and Nutrition Counseling for individuals already diagnosed with diabetes.

D. Strategies to Address Arthritis Incidence:

- Educate the public about ways to help prevent or slow the progression of arthritis and manage the symptoms of joint pain.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area.
- Offer free program to help individuals with arthritis prepare for hip or knee replacement surgery and achieve the best outcome.
- Develop a comprehensive surgical spine program to support individuals experiencing chronic neck and back pain including symptom management and perioperative care.

E. Community Collaboration

An important component of these strategies will be collaboration with community resources including service area town health and human services agencies, schools, senior centers, Chamber of Commerce members, homeless shelters, community physicians as well as ECHN affiliates Rockville General Hospital, Visiting Nurse & Health Services of CT, and Woodlake at Tolland.

F. Measuring the Impact

Measureable impact of the above strategies will take time to materialize, however ongoing analysis of hospital utilization data for specific diagnoses, enrollment in hospital-sponsored education or disease management programs, feedback from community partners and reassessing community health needs in three years will assist in the evaluation of strategy effectiveness.

V. IDENFITIED NEEDS THAT WILL NOT BE ADDRESSED

The hospital will not address the following health needs that were outlined in the community health needs assessment:

- Alzheimer's disease Incidence
- Multiple Sclerosis Incidence
- Substance Abuse
- Childhood Lead Screening

In discussing and prioritizing all of the identified health needs, the Oversight Committee determined that these needs were already being addressed by other healthcare agencies and providers. Additionally, some community needs fall outside the scope of the expertise and resources of the hospital.

VI. APPROVAL

The strategies detailed in this implementation plan have been reviewed and approved by the ECHN's Strategic Planning Committee, including members of its Board of Trustees and the organization's President and Chief Executive Officer:

Milton Doremus
Chair, Strategic Planning Committee
Member, Board of Trustees
Eastern Connecticut Health Network

August 21, 2013
Date

Peter J. Karl
President and Chief Executive Officer,
Eastern Connecticut Health Network

August 21, 2013
Date

Rockville General Hospital

An affiliate of Eastern Connecticut Health Network

Community Health Needs Assessment Implementation Plan

2013

I. INTRODUCTION

Rockville General Hospital (RGH), as part of the Eastern Connecticut Health Network (ECHN), dedicates millions of dollars and thousands of staff hours to activities that enhance the overall health and wellness of its 19-town service area with special focus on the unmet needs of financially disadvantaged and underserved populations.

RGH primarily serves the Connecticut towns of Manchester, Vernon, Ellington, Tolland, Willington, Manchester, South Windsor, Bolton, Coventry and Andover. Its secondary service area includes the towns of Ashford, Somers, Stafford, Union, East Hartford, East Windsor, Glastonbury, Hebron, Columbia and Mansfield. The service areas contain municipalities in Hartford, Tolland and Windham Counties.

In 2013, RGH collaborated with Manchester Memorial Hospital, also an affiliate of ECHN, to conduct a comprehensive community health needs assessment (CHNA). The goals of the assessment were:

- To identify current and future healthcare needs in the community
- To improve and strengthen programs and services provided to address them

The CHNA process was led by an Oversight Committee that included members of the organization with established relationships with community groups and agencies.

Data collected for the CHNA included:

- Health, social, and demographic data specific to RGH's service area obtained from local public health agencies, national health associations and other data sources.
- Health behavior information collected from 1,047 residents who responded to a community survey.
- Input from 12 community stakeholders from local organizations invested in the health of underserved populations.

Once all data was collected and analyzed, the Oversight Committee identified and prioritized the service area's key health needs and developed an implementation strategy to respond to the needs.

This document details the priority health needs that were identified and the implementation plan developed to address them.

II. IDENTIFIED AREAS OF NEED

Analysis of the CHNA data identified the following areas of need:

A. Heart Disease Incidence

Heart disease remains the #1 cause of death in the state and nation. Incidence rates in the service area are similar to national rates. High blood pressure and high cholesterol were the two health conditions most reported among the CHNA survey respondents.

B. Cancer Incidence

Cancer continues to be the second leading cause of death in the RGH service area, in Connecticut, and in the United States. Incidence rate estimates for Cancer (All Sites) and Breast for the total service area are above that of the nation. Prostate and Colon & Rectum cancer rates for the Total Service Area are above both the state and the nation.

C. Diabetes Incidence

Estimated diabetes prevalence rates for 2017 show an alarming increase in the total service area, while state and national estimates remain at or near 2012 rates. An estimated 60,000 to 93,000 adults have undiagnosed diabetes.

D. Arthritis Incidence

There is a higher incidence of arthritis, chronic lower back pain, lower back pain, and neck pain in the service area when compared with national prevalence rates among individuals over the age of 18 years of age.

E. Alzheimer's disease Incidence

There is a higher incidence of Alzheimer's disease among service area residents over the age of 65 compared to national incident rate estimates.

F. Multiple Sclerosis Incidence

The incidence rate of Multiple Sclerosis is higher in the service area when compared to national figures.

G. Substance Abuse

Community stakeholders reported drug and alcohol abuse to be a serious problem in the service area.

H. Childhood Lead Screening

Fewer children in the service area are being screened for lead compared to state percentages but the percentage of children with elevated level levels in the service area remain lower than the state rate.

III. THE PRIORITY NEEDS

The Oversight Committee prioritized the CHNA's identified health needs based primarily on the size and severity of a particular need, and also took into account the hospital's ability to impact the, and availability of resources that exist to address it. Based on these criteria, the following health needs were given the highest priority:

- Heart Disease Incidence
- Cancer Incidence
- Diabetes Incidence
- Arthritis Incidence

IV. STRATEGIES TO ADDRESS PRIORITY NEEDS

The overall goal in addressing each priority needs is to 1. Reduce the preventable risk factors that contribute to incidence of the respective health issue and 2. Promote quality of life for those diagnosed. Each set of strategies will target the broader population with special focus on the financially disadvantaged and underserved populations.

Strategies to Address Heart Disease Incidence:

- Educate the public about managing lifestyle behaviors that impact diet, blood pressure, cholesterol, weight, physical activity, and stress.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area where free blood pressure, cholesterol, body fat composition analysis and educational resources will be shared.
    - Launch the "Freedom from Smoking" smoking cessation program
    - Provide nutrition counseling services
    - Offer integrative medicine programs for stress reduction
- Provide information and services to individuals diagnosed with heart disease to help them best manage their symptoms
    - Offer free "Heart Talk" community program for people living with heart failure

- Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level.

Strategies to Address Cancer Incidence:

- Monitor reports of newly- diagnosed cancer cases in the service area using the National Cancer Center Data Base (NCDB) to identify significant changes, trends or abnormal activity.
- Educate the public about managing lifestyle behaviors that impact cancer risks
  - Cancer Community Outreach Community will coordinate free community health educational lecture and seminar programs.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.
  - Launch the "Freedom from Smoking" smoking cessation program
- Provide free screenings through the community and access to follow-up care
- Offer comprehensive support programs for cancer survivors and caregivers
  - Oncology Nurse Navigator and Survivorship Navigators services
  - Annual Cancer Survivors Day event
  - Regular support group meetings
  - Cancer Caregiver Workshops

Strategies to Address Diabetes Incidence:

- Raise awareness of diabetes preventable risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.

    - Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared.

- Offer Diabetes Self Management Program and Nutrition Counseling for individuals already diagnosed with diabetes.

Strategies to Address Arthritis Incidence:

- Educate the public about ways to help prevent or slow the progression of arthritis and manage the symptoms of joint pain.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area.
- Offer free program to help individuals with arthritis prepare for hip or knee replacement surgery and achieve the best outcome.
- Develop a comprehensive surgical spine program to support individuals experiencing chronic neck and back pain including symptom management and perioperative care.

Community Collaboration

An important component of these strategies is collaboration with community resources including service area town health and human services agencies, schools, senior centers, Chamber of Commerce members, homeless shelters, community physicians as well as ECHN affiliates Manchester Memorial Hospital, Visiting Nurse & Health Services of CT, and Woodlake at Tolland.

Measuring the Impact

Measureable impact of the above strategies will take time to materialize, however ongoing analysis of hospital utilization data for specific diagnoses, enrollment in hospital-sponsored education or disease management programs, feedback from community partners and reassessing community health needs in three years will assist in the evaluation of strategy effectiveness.

V. IDENFITIED NEEDS THAT WILL NOT BE ADDRESSED

The hospital will not address the following health needs that were outlined in the community health needs assessment:

- Alzheimer's disease Incidence
- Multiple Sclerosis Incidence
- Substance Abuse
- Childhood Lead Screening

In discussing and prioritizing all of the identified health needs, the Oversight Committee determined that these needs were already being addressed by other healthcare agencies and providers. Additionally, some community needs fall outside the scope of the expertise and resources of the hospital.

VI. APPROVAL

The strategies detailed in this implementation plan have been reviewed and approved by the ECHN's Strategic Planning Committee, including members of its Board of Trustees and the organization's President and Chief Executive Officer:

Milton Doremus
Chair, Strategic Planning Committee
Member, Board of Trustees
Eastern Connecticut Health Network

August 21, 2013
Date

Peter J. Karl
President and Chief Executive Officer,
Eastern Connecticut Health Network

August 21, 2013
Date

EXHIBIT 25 – OPERATING EXPENSE WITHOUT BAD DEBTS – CT HOSPITALS

Operating Expense Without Bad Debts per Equivalent Case - Adjusted by CMI

	Hospitals	FY 2010	FY 2011	FY 2012
1	Bristol Hospital	$ 5,864	$ 5,757	$ 5,575
2	The Charlotte Hungerford Hospital	$ 5,799	$ 5,700	$ 5,677
3	Windham Community Memorial Hospital	$ 6,145	$ 6,165	$ 5,681
4	Saint Mary's Hospital	$ 5,651	$ 5,791	$ 5,712
5	Manchester Memorial Hospital	$ 5,804	$ 5,775	$ 6,460
6	Day Kimball Hospital	$ 6,522	$ 7,278	$ 6,504
7	The William W. Backus Hospital	$ 6,519	$ 6,293	$ 6,632
8	Rockville General Hospital	$ 6,045	$ 6,837	$ 6,944
9	Johnson Memorial Hospital	$ 6,911	$ 6,753	$ 7,093
10	Lawrence & Memorial Hospital	$ 7,199	$ 7,399	$ 7,395
11	Midstate Medical Center	$ 7,483	$ 7,764	$ 7,651
12	Saint Francis Hospital and Medical Center	$ 7,109	$ 7,617	$ 7,780
13	The Hospital of Central Connecticut	$ 8,307	$ 8,019	$ 8,108
14	Griffin Hospital	$ 7,177	$ 8,298	$ 8,181
15	Middlesex Hospital	$ 7,976	$ 8,616	$ 8,208
16	Waterbury Hospital	$ 7,845	$ 8,652	$ 8,419
17	St. Vincent's Medical Center	$ 8,512	$ 8,334	$ 8,568
18	Milford Hospital	$ 7,530	$ 7,115	$ 8,647
19	Bridgeport Hospital	$ 8,168	$ 8,578	$ 8,783
20	New Milford Hospital	$ 7,951	$ 8,306	$ 9,229
21	The Stamford Hospital	$ 10,274	$ 9,417	$ 9,279
22	Danbury Hospital	$ 8,914	$ 9,155	$ 9,398
23	Greenwich Hospital	$ 8,470	$ 8,747	$ 9,512
24	Hartford Hospital	$ 9,965	$ 10,171	$ 10,341
25	Norwalk Hospital	$ 10,678	$ 10,258	$ 10,397
26	John Dempsey Hospital	$ 9,437	$ 9,863	$ 10,657
27	Yale-New Haven Hospital	$ 11,211	$ 11,497	$ 11,546
28	Connecticut Children's Medical Center	$ 12,448	$ 13,626	$ 13,305
29	Hospital of Saint Raphael	$ 9,060	$ 9,425	N/A
30	Connecticut Acute Care Hospitals Weighted Average	$ 8,760	$ 9,190	$ 9,094
	Simple Average of Hospital Values	$ 7,965	$ 8,180	$ 8,274
	Lowest	$ 5,651	$ 5,700	$ 5,575
	Median	$ 7,845	$ 8,298	$ 8,195
	Highest	$ 12,448	$ 13,626	$ 13,305

This analysis was produced from the data that resides in DataBank Model and OHCA Annual Reports

Source: Certificate of Need Application Docket Number 14-31927-486 (OHCA) and 14-486-02 (AG) St. Mary's Health System, Inc. and Tenet Healthcare Corp. (Appendix V)

EXHIBIT 26 – CURRICULUM VITAE: ECHN

PETER J. KARL

[redacted]

(W) pkarl@echn.org
[redacted]

SUMMARY OF QUALIFICATIONS:

Seasoned chief executive officer with extensive experience in creating new programs and services in small and large not-for-profit Hospital Systems. Well experienced in reengineering initiatives inclusive of significant cost reduction initiatives and program realignment. Strengths include medical staff relations, team building, operations and financial management. A strategic thinker with the ability to grow existing programs, implement new initiatives and operationalize all types of projects, both small and large. In addition, well experienced in funding projects through various avenues; including, but not limited to, joint ventures, REITs, fundraising, short and long term financing, operational surplus' and non-performing asset sales.

PROFESSIONAL BACKGROUND:

July 2004-Present

Eastern Connecticut Health Network (ECHN): Manchester, CT

Eastern Connecticut Health Network is a 320 million dollar health system formed in 1995 consisting of two acute care hospitals (305 beds and 102 beds), a 130 bed long term care facility, VNA/Home Care agency, several free-standing satellite facilities, real estate arm, Physician employment company and various joint ventures (Ambulance Company, Radiation Oncology, Cardiac Catheterization laboratory, Occupational Medicine, Imaging Centers, GI Center, PHO).

December 2004-Present

Eastern Connecticut Health Network: Manchester, CT
President and Chief Executive Officer

- Led organization to first profit in several years in 2005
- Subsequent profits in 2006, 2008, 2009, 2010, 2011, 2012
- Developed new strategic plan comprised of physician partnering, demographic growth, patient quality and financial stability
- Hired 125 new physicians since 2005
- Established NICU services

- Matured hospitalist program, hired orthopedic, general surgeon and GI hospitalists
- Grew physician employment subsidiary from $3 million to $24 million
- Built and opened 2 new free-standing imaging joint ventures
- Acquired competing Imaging Center
- Built and opened new free-standing GI joint venture
- Relocated and expanded Women's Health center
- Constructed new 30 bed Intensive Care Unit
- Constructed new 30 bed addition to LTC facility
- Partnered with physicians to create successful PHO
- Built new 30,000 square foot cancer center
- Formed Physician Strategic Council to gain "non-leadership" physician support
- Established combined Board of Trustee and Physician retreats resulting in cohesive relationships between Trustees, Physicians and Senior Management
- Currently leading an effort to partner with large tertiary or quaternary system in preparation for the PPACA

July 2004-December 2004

Eastern Connecticut Health Network: Manchester, CT
Executive Vice President and Chief Operating Officer

- Hired as successor to existing CEO

October 1999-June 2004

ST. JOSEPH'S HEALTHCARE SYSTEM (SJHS): Paterson, New Jersey

St. Joseph's Healthcare System is a newly formed system consisting of a 792-bed tertiary, inner city medical center; a 229-bed acute care community institution; a 120-bed Long Term Care Facility; and a Visiting Nurse and Hospice Care corporation.

March 2001-June 2004

ST. JOSEPH'S WAYNE HOSPITAL: Wayne, New Jersey
President

- Chief Executive responsible for 229 bed acute care hospital with $70 million operating budget
- In first 10 months reduced annual operating losses from $10.6 million to $1.15 million against a budgeted loss of $3.5 million; through reduction in costs, contract renegotiation and improved revenue.
- Achieved $885K profit in 2002
- Recruited new Senior Management Team
- Recruited 45 new physicians on staff
- Developed 5 year turn-around plan and operational "strategic plan"
- Contracted for Full-time MRI Services (6/01)

- Opened new Senior Acute Care Unit (8/01)
- Launched New Diabetes Program (6/02)
- Worked closely with Executive Director of Foundation and Foundation Board and launched a $3.5 million Capital Campaign (9/02)
  - $1.2 million secured to date
- Lead organization to achieving a score of 95 on JCAHO survey
- Opened new 20-bed Comprehensive Acute Rehabilitation Unit (11/02)
- Developed and opened new Cardiac Catheterization Laboratory (2/03)

March 2001-
June 2004

ST. JOSEPH'S HEALTHCARE SYSTEM
Senior Vice President, Operations

- Executive Management Team Member

March 2001 – January 2003

- Led System-wide $7.0 million non-labor cost reduction initiative
  - Consolidated Pathology Services between both campuses
  - Contracted with single Pharmacy distributor
  - Consolidated Supply Chain and contracted with single GPO
  - Consolidated IT Departments
- "System" responsibilities for the following departments:
  - Radiology Services
  - Pathology
  - Supply Chain

October 1999-
March 2001

ST. JOSEPH'S HOSPITAL & MEDICAL CENTER: Paterson, New Jersey
Vice President, Clinical Services

Recruited by a new management team to develop "Centers of Excellence" for St. Joseph's Hospital and Medical Center

- Administratively responsible for several clinical departments of the 792-bed tertiary care center, to include:
  - Anesthesia Services
  - Cardiology
  - Cardiac Surgery
  - Rehabilitation
  - Radiology
  - Pathology
  - Pharmacy
  - Mobile Intensive Care Unit
  - Orthopedics
  - Medicine
  - Oncology

  - Designed and developed an off-site comprehensive 7,500 square foot Diagnostic Imaging Center (opened 2/03)

- Developed and led a Cardiac Services Task Force to define strategically how Cardiology should be positioned in the institution and community. Created a Department of Cardiovascular Services comprised of both Cardiology and Cardiac Surgery under single leadership

- Assisted the Cardiac Task Force with designing an extensive floor plan to "carve-out" Cardiovascular Services from other overlapping hospital departments

August 1991-
October 1999

STAMFORD HEALTH SYSTEM: Stamford, Connecticut

Stamford Health System: A small health system consisting of a 305 bed hospital, several off-site for profit and not-for-profit entities, a Long Term Care Facility, a CCRC and a 235,000 square foot Ambulatory Care Facility

May 1997-
October 1999

STAMFORD HEALTH SYSTEM:
Project Manager, CS2000 Reengineering Initiative

- Administratively responsible for system-wide reengineering initiative to include:
- Formation of an internal consulting department
- Selection of a nationally renowned reengineering firm
- Development of a five year financial forecast to project Health System's future viability
- Benchmarked SHS against other similar institutions to establish Service, Cost and Quality targets
- Established a cost reduction target of $17-20 million (12-15% of operating costs)
  - Coordinated both Labor and Non-Labor reductions

- Coordinated and oversaw merger and closure of competing hospital; inclusive of merging staff, analyzing direct and indirect costs, and "ramp down" of all hospital services

- Part of Executive Team that designed and developed a $70 million, 235,000 square foot ambulatory care facility

- Worked extensively with Vice President of Foundation to raise capital for new expansion project, including several "naming" opportunities

August 1996-
October 1999

STAMFORD HEALTH SYSTEM: Stamford, Connecticut
Vice President, Ambulatory Services

- Administratively responsible for successful operations of the following Business Units and Departments:

- Imaging Services; to include 2 Healthcare facilities and 2 Free-Standing Centers; combined performing in excess of 130,000 procedures annually.
- Comprehensive Cancer Center; to include an independent Medical Oncology, P.C. and integrated Radiation Oncology Department.
- Free-Standing, For-Profit Retail Pharmacy
- Free-Standing, For-Profit Surgical Center performing in excess of 5,600 procedures annually.
- LLC Partnership in an independent IV Home Therapy and Home Care Company in Central Connecticut.
- Adult, General Care, Ambulatory Services Clinic at 2 Health Care Facilities, combined totaling in excess of 45,000 visits annually.
- Free-Standing Pediatric Ambulatory Care Clinic.

February 1991-
August 1996 THE STAMFORD HOSPITAL: Stamford, Connecticut
Director, Radiological Services

July 1986-
Feb 1991 ST. JOSEPH MEDICAL CENTR: Stamford, Connecticut
Radiology Administrator

July 1983-
July 1986 ST. AGNES HOSPITAL: White Plains, New York
Chief Radiologic Technologist (1984-1986)
Assistant Chief Radiologic Technologist (1983-1984)
Staff Technologist (1983)

EDUCATIONAL BACKGROUND

1994-
1996 UNIVERSITY OF NEW HAVEN: Connecticut
Master of Business Administration (M.B.A.) Degree

1983 DANBURY HOSPITAL SCHOOL OF RADIOLOGIC TECHNOLOGY
Certificate in Radiologic Technology

1979-
1983 SALEM COLLEGE: West Virginia
Bachelor of Science (B.S.) Degree in Management

AFFILIATIONS, COMMUNITY PROJECTS & AWARDS

American Registry Radiologic Technology
Member of Connecticut Hospital Association
Member of American College of Healthcare Executives
1999: Board Member of independent Federally Qualified Health Clinic
2002: Chairman of American Heart Walk for Bergen-Passaic Counties
2005/6: CHA Finance Committee
2007: Board Member, CHA Diversified Network Services
2009: Honorary Chair, Manchester Community College Fundraising Event
2009-present: AHA Regional 1 Policy Board

2010: Received Grassroots Champion Award in Washington, D.C.
2011: Manchester Community College Board of Trustees Merit Award
2011-present: Secretary, CHA Board of Directors
2011-present: Guest Lecturer UConn School of Business
2011-present: UConn School of Business Advisory Board
2011-present: Chairman, CHA Committee on Government
2012: UCONN School of Business Healthcare Management Service Award

COMPUTER SKILLS

- P.C. and Macintosh Systems.

PERSONAL PROFILE

- Married, [redacted]

REFERENCES

- References furnished upon request

MICHAEL D. VEILLETTE

[redacted]

mveillette@echn.org

Senior Vice President of Finance & Chief Financial Officer

Healthcare Financial Executive with nearly 30 years of progressive experience, including 10 years as the top finance decision-maker or second in command of a $300 million dollar healthcare system – 25 years in management. Skilled in financial reporting and analysis, accounting, strategic planning & financial forecasting, budgeting, reimbursement, managed care, treasury functions, captive and insurance oversight, revenue cycle, materials management, health information management and information technology. Demonstrated ability to lead key initiatives, manage professional staff, foster teamwork and build consensus, strategic thought, and achieve goals. Respect of peers for commitment, passion, attention to detail, integrity, and accountability.

Executive Performance

Extensive interaction with Hospital Executives and Board Members. Providing financial results; fiscal and strategic analysis; insight and recommendations on strategic issues and planning. Presents financial reports/results to all Boards (system Board and all Affiliate Boards) as well as to Finance Committee, Investment Committee, Audit Committee and Planning.

Integral part of, and participant in, the annual development of the Hospital's strategic plan.

Key member of the System Acquisition Team comprised of Board members and Hospital Executives.

Restructured the Finance Department to improve overall customer service (internally and externally) and performance.

Integrated the Finance Department into clinical areas to facilitate an understanding of both clinical and financial perspectives on issues.

Cultivated strong collaborative relationships with all c-suite personnel and board members staffed to Finance, Audit and Investment Committees.

Restructuring, stabilizing Information Services for the transition years prior to acquisition.

Employment

Eastern Connecticut Health Network, Inc. • June 2010 – Present, Manchester, CT

Senior Vice President of Finance & Information Services, Chief Financial Officer

Areas of Responsibility & Committees:

Same basic areas of responsibility and staffing to various boards and committees as I held as VP of Finance with the following differences: Report directly to the CEO and now staffed to the Planning Committee and ISSO (Information Systems & Services Oversight) Committee. Also one of two senior team members that have Captive oversight and reporting.

Key Accomplishments:

The last two plus years working to craft a seller's needs list and vet out an acquirer to best position the organization for many future decades of providing quality healthcare services to the community.

Keeping the system financially viable to get through the next few years until it is acquired without breaching any bond covenants, at worse, but with a higher objective of being able to continue independent should acquisition efforts fall through

Worked closely with the CEO as part of a "grassroots" effort to bring attention to and eventually garner pension funding relief via the Pension Relief Act (passed in 2010 and again in 2012) by lobbying our federal legislators down in Washington – made several trips to discuss face to face. This made a substantial difference to our financial future by bringing about more reasonable pension funding obligations.

Worked on another lobbying effort via the Affordable Care Act to bring about additional funding to our two hospitals that qualify for Urban Medicare Dependent Hospital status; still on-going

Financially positioned the System to meet its budgeted surplus target in 2010-12 after raising the financial bar at the beginning of the three year run to prepare to meet the financial challenges of Pension Protection Act and other regulatory changes.

Joined the Chief Financial Officer Roundtable organization – approximately 100-150 healthcare CFO's from around the country participate.

Eastern Connecticut Health Network, Inc. • January 2004 – May 2010, Manchester, CT

Vice President of Finance

$300 million healthcare network with two acute care community-based Hospitals with 351 beds and Subsidiaries including; 100 Bed Skilled Nursing Facility, Diagnostic Imaging Center for Women, Fundraising "Arm", Real Estate Company, Captive Insurance Company and over 20 Physician Practices. Also hold interests in the following joint ventures: Visiting Nurse Company, two Ambulance Companies, Cancer Center, Gastroenterology Free-Standing Facility, and two Free-Standing Imaging Centers.

Areas of Responsibility:
Reports directly to the C.F.O. Directs a finance team of over 110 employees. General accounting, corporate accounting, G.A.A.P. compliance, accounts payable, payroll, treasury, cash management, internal control, tax exempt bond compliance, taxes, external and regulatory reporting, financial analysis and reporting, long range financial planning, budgeting, reimbursement, managed care, revenue cycle improvement, revenue compliance, and financial information systems. Performance oversight of Patient Access, Centralized Scheduling and Patient Accounting areas.

Board Committees:
System Board, Affiliate Boards, Finance Committee, Audit Committee, and the Pension and Investment Committee.

Key Accomplishments:

Point person on establishing the System's financial targets for the next 3-5 years during President Staff Retreat in 2007. First year of new financial vision was FY 2008 – financial target of $8 million from operations was met.

Architect of the change to the paid leave benefit program in FY 2008 which netted nearly $2 million in operational savings.

At forefront of re-charting financial course considering current economic crisis and challenges. Financial goals to remain intact but course to follow has changed and plans have been drafted and will be implemented shortly.

Have been part of team that lead changes to Pension benefits, moving from defined benefit (except for a small few meeting age and tenure criteria) to defined contribution plan to save the system millions in potential funding requirements in future years. Have already realized annual expense savings or expense avoidance with the change for FY 2009.

Improved Revenue Cycle Performance 5 years running while absorbing responsibility of all Managed Care oversight and negotiations while staffing kept flat and in some cases reduced as part of overall hospital "belt-tightening" measures.

Directed the issuance and/or refunding of just under $100 million tax exempt bond offerings for a variety of hospital renovations at both sites spanning the last 10 years through Connecticut's funding agency, CHEFA.

Have also successfully secured other CHEFA sponsored financing (Easy Loan and Easy Lease) to procure other critical clinical equipment needs.

Realized $100,000 annually in additional Medicare Revenue by reviewing and correcting Medicare underpayments related to transfer DRG's.

Increased managed care rates significantly over the past five years by tough negotiating tactics, and through tactical price increases. Have also negotiated several large settlements with major managed care payers on past year's underpayments.

Have been at the point working with Clinical and Operational Leadership on initiatives to squeeze expenses out of the system. In FY 2007, identified $6 million in salary and non-salary expense reduction opportunities that were eventually implemented to achieve full annual benefit for FY 20008. Working with team again in current fiscal year on CRI (cost reduction initiative) to reduce annual expenses by another $4 million.

Serve as member along with Senior VP of Patient Care and VP of Quality on LEAN. LEAN is simply a process of reducing waste – wasted time, wasted energy, and wasted steps. The end game is to improve the efficiency and delivery of a service, to reduce cost and to improve throughput. We have earmarked annually 6-8 initiatives (starting in FY 2007).

Serve as member along with Senior VP of Human Resources and VP of Operations on FHT (Financial Health Team). Collaborative approach to monitor and help manage poor financial performers in the organization at all levels. Eventually can be used as a tool to weed out continued inability to manage financial performance/budget.

Worked closely with the ED on post implementation monitoring of a new system designed to better track patients through the ED throughput process, improved documentation, and track supply utilization and charge capture.

Co-sponsored evaluation and eventually purchase of Surgery Compass software license to identify Operating Room Service trends and cost saving opportunities along service lines or specific to surgeons.

Worked on financial feasibility analysis on the following: new ICU, expansion of Skilled Nursing Facility from 100 beds to 130 beds, move of Women's Wellness Center to new site and acquisition of two digital units, new Wound Care program with hyperbaric chambers, sale of outpatient Dialysis site, Gastroenterology Joint Venture, and two Imaging Joint Ventures.

Eastern Connecticut Health Network, Inc.

Senior Director of Finance (2002-2003)
Reported directly to the Vice President of Finance. Scope of oversight applicable to entire system – hospitals and affiliates. Areas of responsibility included: accounting, budgets, accounts payable, and payroll. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

Director of Finance for Hospitals (2000-2001)
Reported directly to the Vice President of Finance. Scope of oversight applicable to the two hospitals. Areas of responsibility included: accounting, budgets, accounts payable, and payroll. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

Director of Finance for Affiliates (1998-2000)
Reported to the Vice President of Finance and the Administrator of the Skilled Nursing Facility. Scope of oversight applicable to SNF and two other affiliates (Women's Center for Wellness and Physician Practices). Areas of responsibility included: accounting, budgets, external audits, reimbursement, cost reporting, managed care, accounts payable, payroll and other financial analysis. Presented financial results to the affiliate Boards.

Hartford Hospital • July 1989 – November 1998, Hartford, CT

An 867 bed tertiary and teaching hospital affiliated with the University of Connecticut Medical School.

Patient Accounts Manager (1994-1998)
Reported directly to the Director of Patient Financial Services. Departmental liaison to Finance on all reporting metrics. Oversight for Remittance Processing & Cashiers Office, and Self-Pay Unit. Was instrumental in the development and

implementation of automated remittance processing and posting for Medicare, Medicaid, Anthem and several other managed care payer remittances.

Accounting Supervisor (1989-1993)
Reported directly to the Accounting Manager. Primary responsibilities included the month end close calendar and journal entry processing, review of all intercompany transactions and loans, and all fund accounting.

Mount Auburn Hospital • January 1985 – June 1989, Cambridge, MA

A 191 Bed regional teaching hospital closely affiliated with Harvard Medical School.

Assistant Controller (1988-1989)
Reported directly to the Controller. Primary responsibilities included the month end close calendar and all journal entry processing.

Senior Accountant (1987-1988)
Reported directly to the Controller. Primary responsibilities included the month end close calendar and all journal entry processing. Assisted Budget/Reimbursement Department as needed.

Accounts Payable Manager (1986-1987)
Reported directly to the Controller. Responsible for oversight and direction of Accounts Payable staff of four. Department previously lacked organization. Continued to maintain accounting responsibilities.

Staff Accountant (1985-1986)
Reported directly to the Accounting Manager. Assisted Finance Department in various ways including: statistical reporting, cost reporting, budgeting, month end close and analysis, and year end audit requirements.

Education

Boston University • 2013
EMBA -- Executive Master's Business Administration

Eastern Connecticut State University • 1984
Bachelor of Science – Business, Concentration in Accounting.

DENNIS P. MCCONVILLE

[redacted]

PROFESSIONAL EXPERIENCE

EASTERN CONNECTICUT HEALTH NETWORK, INC., MANCHESTER, CT

Senior Vice President Chief Strategy Officer, January 2014 - Present

Senior Vice President for Strategic Planning, Marketing & Communications, April 2007 – January 2014

Vice President for Strategic and Operational Planning, March 2000 – April 2007

- RESPONSIBILITIES: Strategic planning, business development, marketing, communications, public relations, government affairs, physician relations, property management, community health education and benefit reporting for a non-profit health care system with net revenues of $330 million created in 1995 with the merger of two acute care community hospitals having a total of 351 licensed beds, Manchester Memorial Hospital and Rockville General Hospital, and subsidiary corporations including a sub-acute and skilled nursing facility, women's wellness center, a medical foundation, and multiple community-based outpatient services facilities and multiple joint venture companies.
- STRATEGIC PLANNING: Staffing the Board of Trustees initiative to affiliate with a larger regional healthcare system including the evaluation, planning, due diligence, communication plans and regulatory approvals. Developed and oversaw the implementation of three network strategic plans. Created service line plans for women's health, cancer care, surgical services and musculoskeletal services. Collaborated with the Chief Information Officer and produced an information technology strategic plan. Oversaw three community health needs assessments of the network service area. Produced facility master plans and campus plans for two hospitals that included a cancer center. Working closely with the Senior Vice President for Medical Affairs, implemented medical staff development plans including a network primary care strategy. Developed and implemented a network medical access center strategy. Planning for system-wide response to address healthcare payment reform and population health management working closely with Senior Vice President & Chief Medical Officer to further develop ECHN's continuum of care aligning acute, post-acute and community-based care.
- BUSINESS DEVELOPMENT: Established two startup imaging joint venture companies with physicians and other hospital partners. Negotiated the purchase of five physician practices. Formed four real estate joint ventures to develop and build five medical facilities. Obtained regulatory approvals, including certificates of need, for multiple health care services and facilities.
- MARKETING: Managed the development and implementation of a corporate branding campaign and strategic marketing campaigns including a digital media strategy for ECHN and its subsidiary corporations.
- COMMUNICATIONS: Corporate spokesperson for ECHN including crisis communications for union efforts to organize employees and the closure of a hospital maternity service. Lead sponsor of a multidisciplinary team

for internal communication strategy.

- PROJECT MANAGEMENT: Planned, managed and completed multiple facility projects totaling over $100 million including: a major hospital upgrade project, emergency departments, operating rooms, a cancer center, an intensive care unit, hospital-based and ambulatory gastroenterology centers, off-site sterile processing center, ambulatory dialysis center, imaging centers, a behavioral health building, women's health center, and multiple community medical access centers. Worked with the Chief Information Officer to expand the system fiber optic network to all offsite facilities.
- PHYSICIAN RECRUITMENT: Managed the recruitment of 28 physicians for independent physician practices and the ECHN employed physician group practice. Spearheaded a new physician relations program that increased physician retention.

Director, Operational & Strategic Planning, February 1998 - March 2000

- RESPONSIBILITIES: Responsible for business planning, project management, facilities planning, and program development.
- ACHIEVEMENTS: Conducted market share analyses and an extensive community health needs assessment, strategic planning initiatives, maternal and neonatal services and dialysis services studies. Presented community health assessment findings to trustees, medical staff, management staff, staff of nineteen towns, and community and state legislative leaders.

Director of Cardiology, Pulmonary, and Rehabilitation Services, June 1995 - February 1998

- RESPONSIBILITIES: Responsible for leadership and operations management for multiple departments including: physical therapy, occupational therapy, speech therapy, respiratory services, pulmonary laboratory, cardiac stress testing laboratory, cardiac and pulmonary rehabilitation programs, EKG, holter monitor scanning and EEG services.
- ACHIEVEMENTS: Established a sleep study program, designed and implemented a cardiac event monitoring service, established an outreach respiratory and pulmonary rehabilitation program contracted to area skilled nursing facilities, obtained professional service agreements with oxygen/durable medical equipment companies for respiratory equipment teaching in the home, completed a conversion to a CPT-based coding system for rehabilitation services charging, and established a satellite rehabilitation facility with aquatic therapy services at the Glastonbury Wellness Center, Glastonbury, CT.

MANCHESTER MEMORIAL HOSPITAL, MANCHESTER, CT

Evening Administrator, Nursing Services, June 1987 - June 1995

- RESPONSIBILITIES: Responsible as the on-site administrator for the hospital and for clinical nursing services.
- ACHIEVEMENTS: Led a team that developed and implemented a nursing patient care delivery system for nursing.

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER, HARTFORD, CT

Supervisor, Nursing Services, August 1980 - June 1987

- Responsible for clinical supervision of nursing services for critical care and step-down patient care units.

Nurse Clinician, Cardiac Rehabilitation Services, February 1980 - August 1980

- Coordinated and supervised a multidisciplinary cardiac rehabilitation program for patients following myocardial infarction, coronary artery bypass graft surgery and heart valve replacement surgery.

Assistant Nurse Manager, Medical Surgical Intensive Care Unit, February 1979 - February 1980

- Supervised and cared for patients with acute multi-system illnesses, trauma injuries and major surgery.

Staff Registered Nurse, Coronary Intensive Care Unit, July 1977 - February 1979

- Cared for patients with acute cardiovascular disorders.

EDUCATION

RENSSELAER AT HARTFORD, HARTFORD, CT

Master of Science in Health Care Management, June 1995

EASTERN CONNECTICUT STATE UNIVERSITY, WILLIMANTIC, CT

Bachelor of Science Degree, Business Administration, June 1984

SAINT FRANCIS HOSPITAL SCHOOL OF NURSING, HARTFORD, CT

Diploma, Nursing, June 1977

GOVERNANCE AND COMMUNITY ACTIVITIES

Chairman of ECHN Enterprises Board of Trustees (ECHN's for-profit subsidiary) (2000-Present)

Chairman, Board of Directors, Northeast Regional Radiation Oncology Network, Inc. (2013-Present)

President, Tolland Imaging Center, LLC, Tolland, CT (2008–2010), (2013-Present)

Managing Director, Evergreen Imaging Center, LLC, South Windsor, CT (2005-2010)

Board of Directors, Chamber of Commerce, South Windsor, CT (2006–2009)

Board of Directors, Visiting Nurse and Health Services of Connecticut, Vernon, CT (2000-2008)

Vice President and Director, The Rockville Downtown Association, (2001-2005)

LICENSURE

State of Connecticut Registered Nursing License

PROFESSIONAL ASSOCIATIONS

Society for Healthcare Strategy and Market Development of the American Hospital Association

New England Society for Healthcare Strategy

New England Society for Healthcare Communications

Deb Gogliettino, M.S. SPHR

[redacted]

Professional Experience:

2006 to present	**Senior Vice President and Chief Human Resource Officer, Eastern Connecticut Health Network, Manchester, Ct.** $900m gross charges, 2 community hospitals, long term care/rehab facility, VNA network, joint ventures, primary care pods and patient access centers, medical campus in South Windsor, Ct. with 3000+ employees. 4 AFT-CT units, 2 RN, 1 Service and 1 Technical representing 38% of the primary health network work force. Leadership and operational responsibility for Network Human Resources and Organizational Development including Clinical and Organizational education, Food and Nutrition Services, Safety and Security Services and serve as staff to corporate boards of Governance, Non-Corporate Investment Committee, Diversity Committee and Executive Compensation Committee . Reporting to President and Chief Executive Officer
2001 to 2006	**Vice President, Human Resources**, Lawrence Hospital Center, Bronxville, N.Y. community hospital part of a four hospital network with 1480 employees, $119M budget and NY SEIU 1199 unit representing 290 ancillary and support service employees. Leadership responsibility for service excellence in addition to human resources and strategic labor relations. Reporting to President and Chief Executive Officer.
1987 to 2001	**Director of Human Resources at Stamford Health System and Norwalk Hospitals in Connecticut with responsibilities for educational and support service departments. Reported to SVP of Human Resources or SVP of Administration.**

Professional Accomplishments since 2006:

Eastern Connecticut Health Network:

Act as a strategic senior leader and partner with CEO, members of the executive team and members of the Board of Trustees leading to move the organization's culture, address specific business challenges, build the organization's strategic plan and maintaining an organization that meets its mission, vision and values.

Led the transformation of Human Resource operations and services in all disciplines of Human Resources to reflect contemporary Human Resource practices including moving from a defined benefit pension plan to a defined contribution plan in 2009, electronic on-boarding, electronic open enrollment and integration of all sites of the network.

Led the design and development of the Human Resource Connection a central source of data and information for all employees eliminating multiple inconsistent sources. Reduced HR staff by 60% and leveraged technology to move vision forward.

Deb Gogliettino, M.S. SPHR

[redacted]

Professional Accomplishments since 2006 (cont'd):

Sponsor of transformation from paper time and attendance to automated time and attendance recording redefining and eliminating antiquated and inconsistent pay practices and creating one automated platform for the network.

Resource to President and CEO and members of the Executive Board in addressing market position of executive compensation and in building short term and long term incentive programs for the executive team.

Sponsor with President and CEO, current Employee Engagement activities including but not limited to employee survey design and implementation, communication system around results, coaching of the network's Employee Pillar Team, training Employee Engagement leaders, monitoring results and developing on-going communication to the organization about the network's progress towards the key goals.

Chief strategist for labor negotiations and relations with AFT- Connecticut

Developed executive coaching program with master coach consultant for members of the senior management team and director's group. Act as leadership coach to directors and managers, providing counsel and support for department re-designs to meet emerging business strategies.

Executive Sponsor for ECHN Employee Wellness Programs achieving state recognition as STAR awardee from Fairfield County state wide recognition program for outstanding employee participation and results in March, 2014.

Sponsor of Capitol Workforce Partners School at Work program since 2007 providing basic education for interested in pursuing college or promotions at ECHN. ECHN was recognized as an Outstanding Employer in the region by Capitol Workforce in 2009. Serving as co-chair of Finance and Audit Committee for CWP.

Management member of, ECHN Finance, Audit and Compliance, Compliance Operations, Diversity, Corporate Policy, Labor Management, and Senior Strategy Committees.

Additional Qualifications:

*Senior Professional Human Resources d*esignation, 2009 to 2016
Member, CHA HR Board Committee, 2006 to present
Chair, CHA Living Our Mission – Employee Wellness Committee, 2012 to present
Chairperson, CHA HR Executives Committee, 2011 to 2013
Co-Chair CHA Committee on Impact of Healthcare Reform to Workforce, 2011
Member, Executive Briefing on Union Corporate Campaigns, Feb 7, 2006.
Designation Executive Coach through Kaplan University, 2012

Deb Gogliettino, M.S. SPHR
[redacted]

Adjunct Faculty Assignments

Albertus Magnus College, New Dimensions Program (BS and MS level) 1999-2003
Developed new Human Resources Management curriculum for Masters and Bachelors programs.
Faculty Advisor for graduate students completing thesis requirements at Albertus Magnus.

Fairfield University, HR Certificate Program, Employee Relations, Fall 2000, 2001, 2002, 2003

University of Bridgeport, Consulting Skills for the HR Professional, graduate course for members of the MS in HRD and Counseling. Summers 2004-2006

Adjunct Faculty in Management for BBA program at Post College in Waterbury, CT. 1989 to 2000

Education:

2013 Doctoral Student in Education with focus on Organizational Development and Leadership at Grand Canyon University a Division I private university in Arizona. Expected graduation, 2016

2012 Executive Coaching Certificate Program, *Kaplan University*

2008 Completed course work in Project Management at *Manchester Community College.*

2000 MS, *HRD and Counseling, University of Bridgeport, Bridgeport, CT*

1988 MS, *Administration, Western Connecticut State University, Danbury, CT.*

1975 BS, *History, Western Connecticut State College*

References furnished on request.

Deborah A. Parker, MS, RN, NEA- BC

[redacted]

QUALIFICATIONS

Proven track record with over twenty years of progressive, visionary, executive leadership experience. Respected by staff, physicians, managers and colleagues. Strong interpersonal, written and presentation communication skills. Extensive knowledge of regulatory standards to include Joint Commission, CMS, Public Health Code and the like. Effective coach, motivator, mentor, role model, educator and presenter. Strong advocate for quality, evidenced-based patient care. Skilled in quality, safety, regulatory and risk management. Limitless energy, enthusiasm and commitment. Certified trainer in Healthcare High Reliability.

EMPLOYMENT

Executive Vice President and Chief Clinical Officer — **2005 – present**
EASTERN CONNECTICUT HEALTH NETWORK — MANCHESTER, CONNECTICUT

Responsible for the promotion and implementation of high quality nursing and ancillary clinical practice at the two ECHN hospitals, Manchester Memorial and Rockville General, inclusive of inpatient and outpatient programs. Administrative Sponsor for Centers of Excellence for Wound Care, Joint Replacement and Spine and Breast Care Imaging Programs. Work collaboratively with the Executive team in developing clinical programs, promoting collaborative practice with other clinical disciplines and planning, promoting and conducting organization-wide performance assessment and improvement activities. Lead and participate in developing and implementing the philosophy for the provision of patient care consistent with the organization's mission, goals, values and strategic plan, including the redesign of the patient care delivery model. Lead the strategic team related to the establishment and promotion of an organizational commitment to a culture that values quality, safety, contribution and customer service. Redesigned the Quality, Safety and Risk Programs to promote greater collaboration and coordinated work plans. Assumed administrative responsibility for the organization's self-insured captive insurance company. Co-lead the organizations LEAN initiative to balance organizational, financial and quality objectives related to the strategic plan. Develop and maintain consistent standards of Clinical care and practice. Rejuvenated the Clinical ladder program promoting reward and recognition for clinical excellence and leadership at the bedside. The Organizational sponsor for implementation of the principles of Transforming Care at the Bedside (TCAB). Coordinator of organization's plan for Value-Based Purchasing to assure quality patient outcomes and maximum revenue capture. Redesigned the Patient Care and Operating Division to collaborative Clinical Service Lines. Designing network's chronic disease management strategy across the continuum of care to include inpatient, rehabilitation, home care and physician practices to be positioned for healthcare reform and accountable care. Provide administrative direction and resources for assigned departments including surgery, critical care, obstetrics, medical/surgical, psychiatric, neonatal intensive care, case management, infection control, wound management, emergency, ambulatory care and women's wellness, risk management and patient safety with a budget of $100,000,000 and more that 700 FTE's. Collaborated with other organizational leaders in the construction of a $10 million Critical Care Suite. Successfully implemented an outcome based Patient Centered Care delivery model to improve patient, staff and physician satisfaction, enhance clinical outcomes, reduce length of stay and enhance care coordination. Successfully negotiated collective bargaining contracts with the Registered Nurse Unions at Manchester Memorial Hospital and Rockville General Hospital.

Deborah A. Parker, MS, RN, NEA- BC

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Associate Administrator and Patient Safety Officer **2003 – 2005**
THE WILLIAM W. BACKUS HOSPITAL NORWICH, CONNECTICUT

Responsible for the development, implementation, integration and evaluation of the organization's performance improvement, risk management and patient safety programs and plans. Administratively responsible for the departments of Quality Assessment and Improvement, Epidemiology and Infection Control, Risk Management and Credentialing. Coordinate and direct the organizations ongoing preparation, compliance and response to Joint Commission, DPH, OSHA and other regulatory standards. Manage and collaborate with legal council and excess carriers for actual and/or potential medical malpractice and general liability suits and claims. Initiate and execute loss control strategies to prevent, mitigate and lessen risk. Initiated Leadership Safety Rounds to promote a culture of safety, assess compliance and opportunities for improvement related to patient, staff and organizational safety. Developed and implemented departmental dashboards to assess and address important indicators of clinical quality, financial strength, customer service and team strength. Present educational, informational and status reports to Board of Trustees, Department Heads, Medical Staff and Hospital staff on all regulatory, quality and safety issues. Collaborate with Administrative, Medical Staff and Department leaders in policy and program development to promote quality initiatives and improve patient outcomes.

Associate Administrator, Patient Care Services **1987 - 2003**
THE WILLIAM W. BACKUS HOSPITAL NORWICH, CONNECTICUT

Responsible for promoting a participative, decentralized Patient Care Organization. Administratively responsible for 180 FTE's, with annual revenue budget of $34,350,000 and expense budget of $12,500,000 in the areas of Surgical Services (Operating Room, Post Anesthesia Care, Same Day Surgery and Endoscopy), Maternity (Birthing Center, Prenatal Clinic, Breast and Cervical Cancer Early Detection), Nursing/Community Education, Social Services, Case Management, Quality Assessment and Improvement, Risk Management, Epidemiology and Infection Control. Develop, implement and integrate standards of care and practice. Manage and monitor the Patient Care Services Division staffing budget to include allocation of FTE's, allotment of personnel and identification of variances. Coordinate the automated Nursing Management Information System that includes staffing, scheduling, patient classification, productivity and utilization. Coordinate the Patient Care Services Division's ongoing preparation and compliance with JCAHO, DPH and other regulatory standards. Developed patient care technician program in collaboration with local community college in order to prepare for change in skill levels and patient care delivery. Developed and implemented recruitment and retention plan for actual/projected shortages in clinical positions. Plan and present educational and informational programs for medical, nursing and management staff, as well as the community and other organizations.

Coordinator for Staff Development **1981 - 1987**
THE WILLIAM W. BACKUS HOSPITAL NORWICH, CONNECTICUT

Responsibilities included planning, implementing and evaluating the orientation programs for all staff in the Nursing Department. Developed and supervised the Graduate Nurse Preceptorship Program to ease the transition and meet the needs of the entry level practitioner. Planned and presented inservice and continuing education programs for Nursing and Ancillary Departments. Interviewed, screened and hired all candidates for positions within the Nursing Department.

Deborah A. Parker, MS, RN, NEA- BC

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Staff Registered Nurse/Shift Coordinator — **1980 - 1981**
PHOENIX BAPTIST HOSPITAL — PHOENIX, ARIZONA

Critical Care Units (ICU, CCU and Telemetry). Specialized in the care of critically ill adult patients requiring cardiac monitoring, ventilator-assistance, hemodynamic monitoring and other complex nursing functions. Scheduled, supervised and evaluated staff RN's on the evening shift.

Community Health Education Nurse — **1980**
THE WILLIAM W. BACKUS HOSPITAL — NORWICH, CONNECTICUT

Assessed, planned, implemented and evaluated the formalized teaching/learning needs of patients and their families in order to facilitate self-care. Instruction and guidance was provided for patients with diabetes, myocardial infarctions, ostomies, laryngectomies, mastectomies, etc.

Staff Registered Nurse — **1976 - 1980**
THE WILLIAM W. BACKUS HOSPITAL — NORWICH, CONNECTICUT

Intensive Care Unit. Specialized in the care of critically ill adult patients requiring cardiac monitoring, ventilator-assistance, hemodynamic monitoring and other complex nursing functions. Skills utilized included interpretation of cardiac rhythms, starting and maintaining I.V. lines, preparing and maintaining invasive monitoring, i.e. arterial lines, Swan-Ganz catheters, temporary pacemakers, etc.

Staff Registered Nurse — **1975 - 1976**
SISTERS OF CHARITY HOSPITAL — BUFFALO, NEW YORK

Medical Unit. Functioned as the Charge Nurse and Team Leader of a 42 bed Medical Unit. Responsibilities included medication administration, treatments, documentation, care planning, etc.

EDUCATION

Bachelor of Science in Nursing — **1975**
NIAGARA UNIVERSITY — NIAGARA FALLS, NEW YORK

Master of Science in Health Care Management — **1987**
THE HARTFORD GRADUATE CENTER — HARTFORD, CONNECTICUT

Post Masters Certificate in Nursing Administration — **1991**
VILLANOVA UNIVERSITY — PHILADELPHIA, PENNSYLVANIA

Certification in Nursing Administration, Advanced — **1991**
AMERICAN NURSES CREDENTIALING CENTER — WASHINGTON, D.C.

Deborah A. Parker, MS, RN, NEA- BC

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PROFESSIONAL MEMBERSHIPS

American Organization of Nurse Executives (AONE)
Organization of Nurse Executives-CT (ONE-CT)
Connecticut Hospital Association Committee of Patient Care Executives, Chairperson
Connecticut Hospital Association Committee Mental Health and Substance Abuse Services, Chairperson
Board Member Connecticut Allied Health Workforce Policy Board
Board Member ECHN Wellness Services, Inc.
Board Member Evergreen Endoscopy LLC
Board Member Visiting Nurses and Health Services of Connecticut
Board Member Connecticut Healthcare Insurance Company
Member of State of Connecticut Taskforce for Pilot Program to Transfer Hospital Patients Who Receive Medicaid Benefits to Nursing Homes in a Timely Manner

PUBLICATIONS

Parker, Deborah A., (2006, October) Establishing a Passion For Nursing: The Role of the Nurse Leader. *Nurse Leader.*

Adams-Babineau, Sharon, Parker, Deborah, Quirici, Linda. (2005, August) Room to Grow – Clinical Leaders, the CNS Residency Program. *Advance for Nurses.*

Parker, Deborah, Shea, Peter. (March 11, 2004) Patient Safety is the Job of All in a Hospital. *Norwich Bulletin.*

PRESENTATIONS

Utilizing Lean Principles to Balance Operational, Financial and Quality Objectives. American Organization of Nurse Executives Annual Conference, April 27, 2008. Seattle, Washington.

Utilizing Lean Principles to Balance Operational, Financial and Quality Objectives. Connecticut Hospital Association Nursing Leadership Forum, October 23, 2008. Wallingford, Connecticut.

COMMUNITY ACTIVITIES

American Heart Association, Volunteer
American Cancer Society, Volunteer
Susan B. Komen Run for Breast Cancer
Meg Berte Owen Survivorship Program Volunteer

Gregory M. Williams, CPA
[redacted]

SUMMARY

Senior Executive and former business owner with profit and loss experience, a strategic orientation and ability to develop and implement short and long range business strategies in key roles. Key roles included Senior Vice President of Network Services of a two hospital health system, President of a $3 billion in sales financial services firm, Vice President of Strategy and Business Development and Chief Financial Officer of a Fortune 100 financial services firm. My strengths include a focus on people orientated processes, results driven leadership focused on maximizing revenue and earnings growth as well as developing, coaching and mentoring people providing them with upward mobility.

PROFESSIONAL EXPERIENCE

Eastern Connecticut Health Network, Inc. 2013 – present
Responsible for $25.1 million (revenue) health network owned physician group, $3.9 million (revenue) gastroenterology endoscopy center joint venture, $3.5 million (revenue) managed services company, network wide medical staff development planning, physician recruiting and physician relations:

- Led transition to Medical Foundation model.
- Designed and implemented work rvu physician compensation model.
- Led staff and physicians through cultural change process associated with work rvu compensation – achieved 10% productivity growth in year 1.
- Successfully obtained "Meaningful Use" stage 1 and 2 incentives.
- Achieved or exceeded FY 2013 and FY 2014 productivity, quality and financial goals.

Medical Practice Partners, LLC, Vernon, CT 2010 – present
President, physician service company providing medical billing services, electronic medical record selection, contracting, installation, training, go live and support services:

- On behalf of a $12 million (revenue) physician group, negotiated the transition of their medical billing company to a joint venture with a health system. The negotiation process, company formation and transition process led to becoming President of the new entity.
- Over the course of three years, successfully led the company:
  - Through 40% managed turnover and creation of new positions and opportunities.
  - CAGR in revenue of 5.5% during largest health care reform period and industry consolidation.
  - Annual improvement in net income from a loss of ($473.6k) in 2010 to a gain of $377.9k in 2014.
  - Expansion of services from medical billing to electronic medical record consulting & support, IT service & support, human resouree management, bookkeeping and employee leasing. Excluding leased employees, FTE's remain flat with initial year despite growth in revenue and services.
- Recruited (2011) Vice President Operations to groom and became day to day leader of organization in 2013.

KMA Wealth Management, LLC, Tolland, CT 2003 - 2013
Managing Member of a full service fee-based financial planning and business consulting firm serving business owners, medical practices and professionals and corporate executives.

MassMutual Financial Group, Springfield, MA 1998 – 2003

President, MML Investors Services, Inc., MML Distributors, Inc. and MML Insurance Agency (2002 – 2003)
Responsible for all MassMutual retail and wholesale broker dealers and insurance brokerage organizations. MML Investors ranks in top three of insurance affiliated broker dealers:

- Defined organizational vision, fit within the enterprise and key strategic initiatives leading to:
  - Approval of $2 million technology and workflow investment into the business for 2004.
  - Significant role in the successful recruiting of field management talent and financial services professionals.
  - By realigning staff, increased productivity and created opportunities for professional development resulting in a 13% increase in operating margin.
  - Achieved 2003 sales goal of over $3 billion and earnings target despite challenging economic environment.
  - Implementation of a rigorous people development process with succession planning as a primary focus and long term career paths.
- Built very strong, respected relationships with both internal and external key senior executives of product and service providers leading to significant financial support and field satisfaction.
- Managed complex legal and regulatory proceedings.
- Served as primary liaison with field committees representing 85 general agents and 4,000 registered representatives.

Vice President – Field Management Development (2002)

- Developed a vision and implemented new programs to strengthen existing agency management and acquire field management talent to drive accelerated revenue growth and reduced costs. Key member of management team reporting to head of Retail Distribution.
  - Presented acquisition strategy to MassMutual's CEO and senior management team to gain approval for investment.
  - Successfully transitioned five top talent field managers.
  - Created an agency management candidate profile and development curriculum.
  - Designed and delivered a new compensation plan for sales management – a 12 month project, $8 million investment on time and within budget.
  - Hired top talent successor to assume full responsibility going forward.

Vice President – Strategy and Business Development (2000 – 2002)

- Led and developed the first Individual Insurance Group (IIG - Life, Disability Income and Long Term Care Insurance products and Retail and Institutional Distribution) multi-year Strategic Plan and one year Business Plan:
  - Operated as Chief of Staff to Executive Vice President of IIG to assure achievement of committed targets.
  - First holistic multi-year strategic plan including all product lines and distribution organizations.
  - Facilitated sensitive debates on allocation of resources between business heads.
- Senior project manager in the strategic review of the Career Agency System:
  - Evaluated the future of the distribution system: invest in it, harvest it over time or to abandon it in favor of other distribution channels beginning with evaluation of enterprise long term growth objectives and impact of product portfolio, technology, processes, workflows, communications and economics.
  - Evaluation led to a $60 million investment into the Career Agency System through 16 large scale projects. Oversaw the 16 project managers to ensure the projects were delivered on time and within budget.
  - Established very productive relationships with key field managers and home office managers through extensive and sensitive discussions.

2nd Vice President – Chief Financial Officer, Chief Accounting Officer (1998 – 2000)

- Created a business analysis organization focused on financial, competitive and operations analysis, market positioning and capital investment decisions.
- Improved and broadened skills and competencies within the financial organization through talent acquisition and development opportunities.
- Developed and implemented GAAP accounting and improved quarterly closing process:
  - Significant reduction in time to close books.
  - Developed timely, accurate and useful management reporting for senior business heads to aid in business decision making.
  - Installed new reserve calculation system and process.
  - Developed highly effective relationships with key business executives to demonstrate value of financial talent partnering with line of business executives.

CIGNA – Executive Development Program, Bloomfield, CT 1993 – 1998

Rotation assignments in Retirement business, Individual Life and Annuity business and multiple corporate roles:

- Leadership role in divestiture of Individual Life and Annuity business to Lincoln Financial.
- Liaison with Rating Agencies for all CIGNA divisions.

PriceWaterhouseCoopers, Hartford, CT 1990 - 1993

- Staff and management roles on audit engagements in the insurance, banking and non-profit business segments.

EDUCATION & LICENSES

BS Accounting, Southern New Hampshire University, Manchester NH
Certified Public Accountant & Personal Financial Specialist (PFS)
National Association of Securities Dealers Series 7, 24 and 66 registrations, Connecticut and Massachusetts
Life, Accident, Health and Long Term Care Connecticut and Massachusetts Insurance Producer Licenses

AFFILIATIONS

American Society of CPA's
Connecticut Society of CPA's
President & Executive Board Member -Tolland Country Chamber of Commerce
Tolland Economic Community Development Corporation **Board Member**
Town of Tolland Economic Development Commission **Chair**
Executive Director and Treasurer of Tolland Youth Baseball League

JOEL J. REICH, MD, MMM, FACEP, FACPE, CPE

OFFICE: Department of Medical Affairs
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
jreich@echn.org

EMPLOYMENT

1999-present
Senior Vice President for Medical Affairs/Chief Medical Officer
Eastern Connecticut Health Network, Manchester, CT

1997-1999
Chair/Senior Medical Director
Department of Emergency and Ambulatory Care Services
Eastern Connecticut Health Network, Manchester, CT

1984-1997
Chair/Medical Director
Department of Emergency and Ambulatory Care Services
Manchester Memorial Hospital, Manchester, CT

1984-1999
Medical Director
Town of Manchester Emergency Medical Services, Manchester, CT

1981-1984
Attending Physician-Emergency Medicine
The George Washington University Medical Center, Washington, DC

ACADEMIC APPOINTMENTS

2014-present
Adjunct Instructor-Health & Medical Informatics
Rabb School of Continuing Studies, Brandeis University, Waltham, MA

2011-present
Clinical Associate Professor- Emergency Medicine
University of New England College of Medicine, Biddeford, ME

1987-2000
Assistant Clinical Professor-Emergency Medicine
Department of Traumatology and Emergency Medicine, University of Connecticut, Farmington, CT

1982-1984
Assistant Professor-Emergency Medicine
The George Washington University Medical Center, Washington, DC

1981-1982
Instructor-Emergency Medicine
The George Washington University Medical Center, Washington, DC

BUSINESS EXPERIENCE

1993-2005
The Gluten-Free Pantry, Inc., Glastonbury, CT

LICENSURE

State of Connecticut (1984-present)

CERTIFICATION

Graduate Certificate, Health and Medical Informatics (2013)
Health IT Leadership Certification, American College of Physician Executives (2012)
Board Certified, American Board of Emergency Medicine (ABEM) (Recertified 2010)
Fellow, American College of Physician Executives (FACPE)

Certified Physician Executive (CPE), The Certifying Commission in Medical Management
Fellow, American College of Emergency Physicians (FACEP)

POSTGRADUATE CLINICAL TRAINING

1979-1981
Emergency Medicine Residency (PGY II and III)
Georgetown University Joint Residency Program, Washington, DC

1978-1979
Internal Medicine (PGY I)
The George Washington University Medical Center, Washington, DC

EDUCATION

2014
Online Instructor Training, Rabb School of Continuing Studies, Brandeis University, Waltham, MA

2010-2013
M.S., Health & Medical Informatics, Rabb School of Continuing Studies, Brandeis University, Waltham, MA

2002-2003
M.M.M. (Master of Medical Management), Heinz School of Public Policy and Management, Carnegie Mellon University, Pittsburgh, PA

1974-1978
M.D., School of Medicine, SUNY at Buffalo, Buffalo, NY

1973-1974
M.S. (Technology and Human Affairs), Sever Institute of Technology, Washington University, St. Louis, MO. Thesis: Telemedicine: The Assessment of an Evolving Health Care Technology
www.eric.ed.gov/PDFS/ED095883.pdf

1969-1973
B.A. (Biology), Brandeis University, Waltham, MA

PROFESSIONAL ACTIVITIES

Clinically Integrated Network of Eastern Connecticut (CINECT)
Chief Medical Officer (2014-present)
Board of Directors (2014-present)

Brandeis University Graduate Professional Studies Advisory Board: Health and Medical Informatics (2013-present)

Quinnipiac University School of Medicine Mentoring Program (2013-present)

Connecticut Hospital Association
Board of Trustees (2005-2011)
BOT Committee on Human Resources (Chair 2006-2011)
Advisory Committee on Transfer of Patients with Advance Directives (Chair: 1993-1997)

Connecticut Healthcare Insurance Company (CHIC)
Board of Directors (2006-present)
Claims Committee (2009-present)

Eastern Connecticut Medical Professionals Foundation (Multispecialty physician group)
Board of Directors (2000-present)

Eastern Connecticut Physician Hospital Organization (ECPHO)
Board of Directors (2005-present)

Ambulance Service of Manchester
Board of Directors (2000-present)

State of Connecticut EMS Advisory Board (1992-2002)
Chair (1997-2001)
Vice Chair (2001-2002)
Dedicated Funding Committee (Chair: 1993-1995)
Trauma Committee and Hospital Trauma Peer Review Sub-Committee (1994-1996)
Director's Search Committee (1992-1993)

Town of Manchester EMS Council
Chair (1984-1999)

Town of South Windsor EMS Commission (1988-1993)

North Central Connecticut EMS Council
President (1990-1992)
Board of Directors (1987-present)
Medical Advisory Committee (1984-1999; Co-chair: 1994-1995)
University of Connecticut Health Center-Manchester Memorial Hospital
Paramedic Training Course (Co-Director) (1986-1988)
Towns of Manchester, Bolton, Coventry, Glastonbury, South Windsor
Medical Director, EMT Certification and Recertification (1984-1999)

AWARDS
Star Award: Core Values (ECHN)
Volunteer Service Award (Habitat for Humanity)
Public Service Award (State of Connecticut/Governor EMS Advisory Board)
Richard H. Meny Award (NCCEMS)

COMMUNITY ACTIVITIES
Camp Merriwood (Girl Scouts), Medical Advisor (1985-1999)
Habitat for Humanity (1994-2007)
Manchester CPR Project, Medical Director (1985-1999)
Manchester Road Race, Medical Director (1989-1999)
Primary Health Care Task Force, Town of Manchester (1993-1995)
Visiting Nurse Association of Manchester, Physician Advisor (1992-1995)

LEGISLATIVE INITIATIVES
DNR (Do Not Resuscitate) Transfer state law and regulations
Emergency Care federal regulations: "Prudent Layperson" definition of emergency condition.

PROFESSIONAL SOCIETY MEMBERSHIPS
American College of Physician Executives (ACPE)
Council of Fellows (2005-2009)
Healthcare Information and Management Services Society (HIMSS)
Association of Medical Directors of Information Services (AMDIS)
American College of Healthcare Executives (ACHE)
American College of Emergency Physicians (ACEP)
Emergency Medical Services Committee (1994-1997)
American College of Emergency Physicians, Key Contact Program (Barbara Kennelly, D-CT), 1992-1997
Connecticut College of Emergency Physicians (CCEP)
Board of Directors (1985-1992)
Alternate Councilor to ACEP (1991-1995)
American Telemedicine Association (ATA)
American Medical Association (AMA)
Hartford County Medical Association (HCMA)
Tolland County Medical Association (TCMA)
Connecticut State Medical Society (CSMS)

PRESENTATIONS AND PUBLICATIONS

PRESENTATIONS

"The Views of Healthcare Industry Stakeholders", Healthcare Leadership Panel , 2014 National Association for Home Care & Hospice (NAHC) Financial Management Conference & Exposition, Chicago, IL, July 2014.

"Accountable Care's Leadership and Governance Challenges", Keynote/Panel, National Healthcare CMO/CMIO Summit 2014, Las Vegas, NV, March 2014.

"Roadmap: Emerging Roles, Priorities and the Need for Cross-Functional/Cross-Institutional Partnerships", Closing Keynote, HTRAC (HealthTech Research Advisory Council), Washington DC, November 2013.

"The Future in Healthcare", The Business Alliance for Community Health (BACH). Manchester, CT, August 2013.

"It Takes a Village to Grow a Network", Brookings-Dartmouth ACO Learning Network: What's Next for Measuring & Improving Care in ACOs? Washington, DC, April 2013.

"HIT Challenges of Accountable Care", 2011 Meditech Physician Forum, Canton, MA, October 2011.

"10 Things to Do…if You are Not One of Those Famous Clinics: Aligning your Hospital with Your Physicians", World Health Congress Leadership Summit on Clinical Integration, Fairfax, VA, December 2010.

"5 Ways to Hospital-Physician Quality" Webinar. HCPRO, November 2009.

"The Dynamic State of Physician-Hospital Alignment: Using Collaboration and Strategy to Drive Success", American College of Healthcare Executives (ACHE) 2009 Congress on Healthcare Leadership, Chicago, IL, March 2009.

"Alignment Strategies", South Shore PHO, S. Weymouth, MA, July 2008.

"Primary Care Alignment Strategies", New England Society for Healthcare Strategy (NESHS) Spring Conference: Magic in the Minefield: Physician Alignment and You", Westborough, MA, May 2008.

"The Dynamic State of Physician-Hospital Alignment: Practical Strategies to Ensure Your Success", American College of Physician Executives (ACPE) Spring Institute, New York, NY, April 2008.

"Advance Directives", Eastern Connecticut Health Network, Manchester, CT, October 2005.

"Create an Emergency Department Observation Unit for the 21st Century", Observation Units for the Emergency Department, Lake Buena Vista, FL, November 1998.

"Automatic External Defibrillation Training Seminar", American Red Cross, Farmington, CT, November 1998.

"The Cardiovascular Patient in the Emergency Department", Catastrophic Injuries and Cutting Edge Issues, American Bar Association, Amelia Island, FL, February 1998.

"The DNR Transfer System", Connecticut Hospital Association, Wallingford, CT, May 1997.

"Emergency Department Design for the 21st Century: Ten Emerging Trends in Emergency Medicine Practice", South Jersey Hospital System, Vineland, New Jersey, November 1996.

"How to Design an Emergency Department for the Year 2000", Clinician's Update: 1997 (Presented by Washington Hospital Center), New Orleans, LA, September 1996; University of Connecticut, Farmington, CT, November 1996.

"Complaints, Complainers, and Risk: How to Stay out of Trouble in the E.D.", Grand Rounds, University of Connecticut Emergency Medicine Residency Program, April 1996; Yale University, New Haven, CT, October 1996.

"Implementation of a Statewide Trauma System in Connecticut," Connecticut Hospital Association, Wallingford, CT, April 1995.

"Medical Control-On-Line", EMS Medical Control Course, University of Connecticut Health Center, Farmington, CT, October 1990; October 1994; October 1995; October 1996.

"The EMS System. Does It Make A Difference?", EMS: Your Decision, A Workshop for Government Officials, Hartford, CT, June 1988.

"Communication, The Essence of Medical Control", Physicians' Base Station Symposium, Wallingford, CT, October 1986; April 1988.

"Medical Control: Who's In Charge?" and "Emergency Department and Ambulatory Care Centers", Connecticut EMS: A System of Challenge and Change, State of Connecticut Office of Emergency Medical Services, Cromwell, CT, March 1987.

"Recognition and Management of Cyclic Antidepressant Overdose", St. Vincent's Medical Center, Bridgeport, CT, November 1986.

"My Ups and Downs: Falls in the Elderly", Geriatric Emergencies, Manchester, CT, March 1986.

"Marketing the Emergency Department, Emergency Nurses Association (ENA), Manchester, CT, October 1985.

"Spider Bites", Pitfalls and Pearls Conference, Washington, DC, May 1984.

"Softball: The Summer Epidemic", R. Shesser, M. Smith, J.J. Reich, S. Edelstein, University Association for Emergency Medicine (UAEM), Boston, MA, June 1983.
"Emergency Medicine Residency Training Programs", Society for Teachers of Emergency Medicine (STEM), Boston, MA, June 1983.
"From Basin-to-Basin: Fish Toxin Poisoning", Pitfalls and Pearls Conference, Washington, DC, April 1983 and Toxindromes Conference, Washington, DC, December 1983.
"Paramedic Telecommunications", DCFD Emergency Ambulance Service Training, Washington, DC, April 1981; September 1981.
"Arrhythmias in Tricyclic Antidepressant Overdose", Pitfalls and Pearls Conference, Washington, DC, December 1981; April 1982.
"EMS Communications", Physician's Base Station Symposium, American College of Emergency Physicians, Washington, DC, April 1982; June 1982.

EDUCATIONAL LECTURES, PROGRAMS AND COURSES

Health & Medical Informatics Leadership: online graduate level course (in preparation, 2014)
Legal Pitfalls of Healthcare System Reform: online lecture (2014)
Healthcare Management and Organizational Leadership: Physician Leaders (2013)
Introduction to Health Informatics (2013)
Introduction to US Health Policy (2012 & 2013)
DNR Transfer System Training Program (1997)
Pre-hospital 12-Lead ECG Training Program (1996)
First Responder Defibrillation Program (1995)
EMT-Epinephrine Training Program (1989)
EMT-Defibrillation Training Program (1988)
"Immunize and Protect Your Child" (consultant to WHO pre-production group, 1976)

PUBLICATIONS

McNulty A, Reich JJ. Survey and interviews examine relationships between physicians and hospitals. Physician Executive, September-October 2008:48-50.
Reich JJ: "Observation Unit Design" in Graff L (ed). Observation Units: Implementation and Management Strategies. Dallas, TX, American College of Emergency Physicians, 1998.
Turbiak TW, Reich JJ, "Bacterial Infections" in Rosen P, et al (eds). Emergency Medicine (Third Edition), St. Louis, MO, C.V. Mosby Co., 1992; (Fourth Edition), St. Louis, MO, C.V. Mosby Co., 1998.
Reich JJ: "Nontraumatic ear disorders" in Howell JM, et al (eds) Emergency Medicine, Philadelphia, PA, Saunders, 1998.
Turbiak TW, Reich JJ: "Bacterial Infections" in Rund D, et al (eds): Essentials Of Emergency Medicine. St. Louis, MO, C.V. Mosby Co., 1996.
Calabro J, Rivera EJ, Reich JJ, Krohmer JR, Balcombe J: Provision of emergency medical care for crowds. American College of Emergency Physicians, 1996.
Gabram SGA, Libby MCN, Jacobs LM, Atweh N, DeGutis L, Reich JJ, Ryan N, Thomas RG, Zelman J. Peer Review of On-Scene Air Medical Triage in Connecticut. Connecticut Medicine, 1994; 58:3-12.
Turbiak TW, Reich JJ: "ENT Emergencies" in Stine RJ and Marcus RH (eds). Practical Approach To Emergency Medicine (Second Edition), Boston, MA, Little Brown & Co, 1994.
Turbiak TW, Reich JJ: "Sudden hearing loss" in Harwood-Nuss A, et al (eds). The Clinical Practice of Emergency Medicine, Philadelphia, PA, J.B. Lippincott Co, 1990.
Reich JJ: Ear infections. Emergency Clinics of North America 1987; 5:227-242.
Reich JJ, Turbiak TW: "Ear Emergencies" in Stair T, (eds). Eye, Ear, Nose Mouth and Throat Emergencies, Rockville, MD, Aspen Systems Corporation, 1986.
Reich JJ, Turbiak TW: "Ear Emergencies" in Stair T, (eds.). Topics in Emergency Medicine: ENT Emergencies, Rockville, MD, Aspen Systems Corporation, 1984.
Reich JJ: "Telemedicine: The Assessment of an Evolving Health Care Technology". Report Numbers: RCT-74/4 and THA 7416 Center for Development Technology. St. Louis, MO (National Technical Information Service. [N74-76939], 1974). www.eric.ed.gov/PDFS/ED095883.pdf

PRODUCTIVITY SOFTWARE EXPERIENCE

Microsoft Office: Word, Excel, Access, Outlook

Joyce Tichy
[redacted]

EXPERIENCE

Eastern Connecticut Health Network January 2, 2013 -present
Manchester, Connecticut
Senior Vice President and General Counsel

Integrated not for profit community health care delivery system serving 19 towns in eastern Connecticut through a network of facilities including two community hospitals, skilled nursing and rehabilitation center, multi-specialty physician group, visiting nurse service and cancer center.

Responsibilities:

- Manage all litigation and legal functions of the system
- Maintain contract compliance under Stark and Anti-Kickback Statute
- Negotiate EMR and other IT licensing
- Handle contract negotiations with payors, vendors and strategic partners, including physician groups, DME vendors and care coordination entities
- Manage legal aspects of employee relations and employee benefits
- Handle legal matters relating to medical staff functions and patient care
- Ongoing legal and regulatory advice to CEO, CFO, CMO, CCO and other senior management
- Select, monitor and manage outside counsel
- Board of Trustees legal advisor on not for profit and charitable foundation board governance matters
- Legal advisor to compliance and privacy functions, including HIPAA Privacy and Security Rule

APS Healthcare 2008-2012
White Plains, New York
Senior Vice President, Chief Legal Officer and Corporate Secretary

Privately held specialty health care services/health information technology company furnishing data analysis, data stratification, care coordination and disease management services for persons with complex and chronic care needs. Company also furnished health/wellness and mental health services to public health (TANF, ABD, ADHC) programs and employer-sponsored benefit plans. Operations throughout the United States and Puerto Rico.

Responsibilities:

- Managed all legal functions of the company
- Managed DOJ qui tam litigation, negotiation of CIA and subsequent CIA compliance
- Managed legal intellectual property protection strategy (work-for-hire, patent, trademark, licensing)
- Managed legal aspects of agreements with all customers and vendors
- Managed legal aspects of employee relations and employee benefits, including employee stock plan
- Handled contract negotiations with strategic partners
- Supervised legal aspects of mergers and acquisitions activities
- Supervised maintenance of corporate operating licenses
- Ongoing legal, regulatory and corporate governance advice to CEO, CFO, COO and senior management
- Selected, monitored and managed outside counsel
- Corporate Secretary, handling all corporate resolutions, bylaws amendments and maintenance of other

corporate governance documents.
- Reorganized/relocated all legal functions in 2008 subsequent to purchase of company from prior owner
- Supervised institution of contract electronic imaging process 2008-09
- Supervised compliance and privacy functions

Liberty Health System, Inc. 2006-2008
Jersey City, New Jersey
Senior Vice President and General Counsel

Not for profit New Jersey safety net hospital/health services system comprised of 3 hospitals and 14 business units across 10 sites.

Responsibilities:

- As system's first in-house General Counsel, created internal legal function.
- Managed legal aspects of hospital system turnaround under supervision of New Jersey regulatory authorities
- Managed legal aspects of closure of one of three system hospitals and of disaffiliation with federally qualified health center
- Instituted corporate compliance program, including documentation of Stark and anti-kickback compliance for physician contracting and leasing arrangements, and revisions to Code of Conduct
- Led system-wide physician re-contracting initiative for approximately 185 physicians
- Managed legal aspects of ongoing physician recruitment initiatives and vendor, outsourcing and managed care contracts
- Negotiated contract with strategic medical center partner for perinatal/neonatal services
- Handled all legal real estate matters, including physician office building construction
- Managed insurance and risk management function
- Managed all formal and informal dispute resolution processes, including litigation, malpractice matters, lawsuits against health insurers, employment claims and investigations, patient care and patient rights issues, reports to professional licensing entities, and other regulatory reporting
- Revamped hospital bylaws and reincorporated and reconstituted hospital boards to realign hospital and parent board functions
- Advisor to all HR functions; handled all legal employment/severance related matters
- Ongoing corporate governance advice to hospital and parent boards
- Ongoing legal and regulatory advice to CEO, CFO, COO and all other senior management
- Selected, monitored and managed outside counsel
- As Board of Trustees legal advisor, attended and provided advice in Board meetings for parent and subsidiary hospitals, and furnished ongoing counsel to Board on corporate governance. Handled all corporate resolutions, bylaws amendments and maintenance of other corporate governance documents.

WellPoint/WellChoice./Empire Blue Cross and Blue Shield 1993-2006
New York, New York
Associate General Counsel, Vice President Risk Management, Chief Privacy Officer, 2002-2006
Vice President and Associate General Counsel, 2000- 2002
Assistant Vice President and Associate Counsel, 1996-2000
Director and Associate Counsel, 1993-1996

Largest health insurance company in New York State, serving 5.2 million members.

Responsibilities:

- Negotiated major human resources, outsourcing, benefits, hospital and ancillary provider contracts
- Lead Counsel for e-business subsidiary NexxtHealth – set up and incorporated company, handled all legal functions, negotiated all contracts/licensing agreements, created and implemented stock option plan
- Risk Management Attorney/Officer
    - Created and implemented corporate-wide safety policy and safety committees, thereby decreasing workers compensation claims
    - Obtained $74 million 9/11 World Trade Center insurance recovery. Corporation attained funds to rectify disaster-related damage to operations
    - Managed error and omissions recovery (approximately $4 million) in national class action
    - Conducted complex and sensitive litigation, managed litigation attorneys
    - Designed insurance portfolio for newly public company
- Chief Privacy Officer
    - Implemented federal HIPAA law and state information security laws
    - Managed all privacy breach investigations, compliance and contracting issues
    - Developed and co-chaired corporate Cross Functional Privacy/Security Committee
- Corporate employment, benefits, labor and ERISA counsel
    - Managed downsizing of organization from 10,000 to 5,000 employees, negotiated numerous senior executive severance agreements, and investigated and resolved numerous employment claims, all at minimal legal liability.
    - Handled conversion of $500 million pension to cash balance plan, retiree benefit changes, and ensuing legal challenges.
    - Implemented all legal changes to employee benefit programs (e.g. Health Savings Accounts).
    - Interim Senior VP, Human Resources and Services. Maintained continuity in Human Resource function during two management transitions.

Vladeck, Waldman, Elias & Engelhard, P.C., New York, New York
Associate, 1986-1989; 1990-1993
Practice in labor, employment and employee benefits law. Negotiation, litigation, arbitration and representation before government agencies. Handled cases from inception through appeal.

Cleary, Gottlieb, Steen & Hamilton, New York, New York
Associate, 1989-1990
General corporate practice, including complex commercial and real estate transactions, corporate financing and securities law compliance.

Honorable H. Lee Sarokin, United States District Court District of New Jersey (now retired) Newark, New Jersey
Law Clerk, 1985 -1986

Honorable Robert S. Vance, United States Court of Appeals, Eleventh Circuit (now deceased) Birmingham, Alabama
Law Clerk, 1984 - 1985

EDUCATION

Harvard Law School, J.D. June 1984, cum laude,
Editor, Harvard Law Review, Legal Writing Instructor, Teaching Assistant

Wesleyan University, M.A.L.S. May 1981, Major: Literature

Yale University, B.A. May 1978, summa cum laude, Major: Literature

BAR ADMISSIONS

New York, New Jersey, Connecticut, S.D.N.Y., E.D.N.Y.

PROFESSIONAL AFFILIATIONS

Member, New York State Bar Association Health Law Section Public Health and Medical Device & Biotechnology Committees
Former Member and Chair, New York City Bar Association Health Law Committee
Member, American Health Lawyers Association
Member, New Jersey Bar Association Health Law Section
Member, Connecticut Bar Association Health Law Committee

M. Maher Suede, MD.FACS.

272 Main Street
Manchester, CT. 06042
Tel: 860-4322100
Fax: 860-4325330
[redacted]
Website: suedesurgicalcare.com

PERSONAL

Board Certified in the field of General Surgery, in addition to having a large experience in Advanced Laparoscopic Surgery, and a great interest in breast, thyroid, and varicose veins surgery.
Currently, practicing General and Advanced Laparoscopic and Robotic Surgery in Manchester, Connecticut.

EDUCATION

- 12/2007 passed the **Recertification Exam of the American Board of Surgery.**
- 10/2006 attended **Laparoscopic Hand Assisted Colon Surgery Workshop,** at the University of Massachusetts, Shrewsbury, Massachusetts.
- 7/2006 attended **Laparoscopic Intestinal Surgery Workshop,** at the Lahey Clinic, Burlington, Massachusetts.
- 5/2003 attended an intensive course in **Advanced Laparoscopic Surgery** at the University of Strasbourg, Strasbourg, France.
- 10/1999 received the certification of the **American Board of Surgical Critical Care.**
- 11/1998 received the certification of the **American Board of General Surgery.**
- 7/1997-6/1998 **Fellowship in Surgical Critical Care,** at Hartford Hospital, University of Connecticut, Hartford, Connecticut.
- 7/1993-6/1997 **General Surgery Residency,** at New York Methodist Hospital, an affiliate of Cornell University, Brooklyn, New York.
- 7/1991-6/1993 **General Surgery Residency,** at Monmouth Medical Center, New Jersey.
- 3/1991 Received the **ECFMG Certificate.**
- 3/1990-3/1991 **Worked as a research and clinical associate,** at the Division of Pediatric Surgery, at Harbor-UCLA Medical Center, Torrance, California.
- 8/1989 **Graduated from Damascus University School of Medicine.**

EMPLOYMENT:

- 7/1997-9/1999 Attending physician in Surgical Critical Care at Saint Francis Hospital, Hartford, Connecticut. During that period I had the responsibility of managing all aspects of critical surgical and trauma patients in a 12 bed SICU and a 6 bed intermediate care unites, at a level one trauma center, with a busy general, vascular and thoracic surgical services.
- 1/2000- 2/2005 Private General Surgery practice at Cham Clinic Damascus, Syria.

Practicing In a multi-specialty group, with a busy urgent care, in the center of Damascus city, and operating in many of the city's private hospitals.

- 10/2000- 4/2002 served as the Director of Surgical Critical care, Al-Assad University Hospital, Damascus, Syria.

In which I had the duty of managing a three unit surgical intensive care, that included cardiothoracic, neurosurgical and a general surgical unit.

- 3/2005- 6/2008, Private Practice in General Surgery, with Dr. Laureen Rubino, MD. Manchester, Connecticut.
- 6/2008- 3/2010 General Surgery, at Eastern Connecticut Health Network Health Services.
- 4/2010- present General Surgery private practice at Suede Surgical Care LLC.

Professional Society Membership:

Fellow of the American College of Surgeons.
Fellow of the American Society of breast surgeons.

Hospital Affiliation:

- Manchester Memorial Hospital, Manchester, Connecticut.
- Rockville General Hospital, Rockville, Connecticut.
- Saint Francis Hospital, Hartford, Connecticut.

References

- **Leslie Wise, MD.**
  Chairman Department of Surgery
  New York Methodist Hospital
  506 Sixth Street
  Brooklyn, NY. 11215
  Tel: 718-780 3000
- **Kevin Keating, MD.**
  Program Director
  Surgical Critical Care
  Hartford Hospital
  80 Seymour Street
  Hartford, CT.06102
  Tel: 860-545 5000

- **Dr. Joel Reich, MD.**
  Senior Vice President of Medical Affairs.
  Manchester Memorial Hospital
  71 Haynes Street
  Manchester, CT. 06040
  Tel: 860-6461222

Mary E. Powers

[redacted]

Objective

Profile

- One year experience Senior Vice President, Patient Care Services
- Two years experience Vice President, Patient Care Services
- Six years experience as Director, Patient Care Services.
- Goal-oriented individual with strong leadership capabilities.
- Organized, highly motivated, and detail-directed problem solver.
- Proven ability to work in unison with staff, physicians, and nursing units throughout the organization.

Education

D.N.P. student-Leadership Cohort, American Sentinel University-expected completion February 2015

M.S.N., Management, University of Hartford 2004
B.S.N., Cum Laude, Central Connecticut State University 2000
Diploma R.N., Saint Francis School of Nursing 1982

Relevant Experience & Accomplishments

Leadership

- ICD-10 Implementation Project
- Meaningful Use Steering Committee
- High Reliability Steering Committee
- Cost Reduction Efficiency Workgroup, co-lead of the group that developed staffing metrics for all direct patient care area.
- Value Based Purchasing Steering Committee
- Service Line development

Projects

- Heart Failure Patient Education Program
- Primary Stroke Designation (team member)
- Implementation of Bedside Medication Verification
- Oversight of new physiological monitoring equipment throughout both hospitals

Committees

- Operating Committee-Chair
- Clinical Practice Committee
- Readmission Committee-Chair (Heart failure, COPD, Pneumonia)
- Stroke Committee-member

Employment

Senior Vice President, Patient Care Services, *Eastern Connecticut Health Network* — *2013-presen*

- Direct Reports-Oncology, Behavioral Health, Cardiovascular/Neurology Service Line Directors, Pharmacy, Medical Surgical Nursing and Nursing Informatics
- Oversight Sound Physicians-hospitalist contracted service

Vice President, Patient Care Services, *Eastern Connecticut Health Network* — *2011-2013*

- Direct Reports-Oncology, Behavioral Health, Cardiovascular/Neurology Service Line Directors, Pharmacy, Medical Surgical Nursing and Nursing Informatics

Director, Patient Care Services, *Eastern Connecticut Health Network* — *2007-2011*

- Nursing Informatics Liaison
- Nursing Quality Representative
- Direct Reports-Nursing Education Manager, Nursing supervisors, and Nurse manager of ICU and Medical-Surgical unit

Clinical Nurse Manager , *Rockville General Hospital* — *1999-2007*

- Oversees the day to day operations of a 9 bed Intensive Care Unit and a 38 bed Medical-Surgical Unit.
- Oversees approximately 58 ftes

Nursing Supervisor/Resource Nurse, *Rockville General Hospital* — *1993-1999*

- Responsible for placing patients within the hospital on the off shifts.
- Resource person for any clinical issues that arose.
- Responsible for managing staffing concerns that developed on the off shifts.

Staff Nurse, *Intensive Care Unit*, Rockville General Hospital — *1987-1999*

- Direct patient care for critically ill adults.

Staff Nurse, *Medical Floor*, Rockville General Hospital — *1982-1987*

- Direct patient care for acutely ill adults.

Community Involvement

Board Member Northeast Region Radiation Oncology

Board Member-Walden Behavioral Care

License & Certifications

Registered Nurse License

Nurse Executive Advanced, Board Certified, *Professional certification*

Role Excellence in Leadership, *Post Master certificate, Villanova University*

CURRICULUM VITAE

Name: Pamela Lewis
Home Address: [redacted]
Business Address: OB-GYN Group of Eastern Connecticut, P.C.
360 Tolland Turnpike, Suite 3B
Manchester, CT 06042-1759
Business Phone: (860)6461660
[redacted]

Education

1979-1982	Southeastern Massachusetts University, North Dartmouth, MA. B.S in Biology, High Distinction
1984-1988	University of Miami School of Medicine M.D.
1989-1990	Internship, Department of Obstetrics and Gynecology Mount Sinai Hospital, Hartford, CT
1990-1993	Resident, Department of Obstetrics and Gynecology Mount Sinai Hospital, Hartford, CT

Employment

1993-Present	Managing Partner, OBGYN Group of Eastern Connecticut, P.C Manchester, CT
2006-Present	Managing Partner • Administrative responsibilities • Review collections and the billing Department • Negotiations of HMO contracts

Hospital Appointments

2014- Present	ECHN President, Medical Staff • Chair, Medical Executive Committee • Member ECHN Board of Trustees

2013-present	Associate Director, ECHN Medical Education • Assist the Director , ECHN Medical Education
2012-2013	ECHN Vice President, Medical Staff • Affiliation Work Group • Chair, Quality Improvement Council ➢ Presentation: Retrospective Review of 3rd and 4th Degree Tears in OB Patients at Manchester Memorial Hospital
2011-present	Clerkship Director, ECHN/UNECOM Medical Student Program
2008-2011	ECHN Chair, Department of Obstetrics and Gynecology • Organization of multidisciplinary conferences • Integration of Mock Stimulation Programs • QA and Peer Review • Administrative responsibilities • Development of the FBC Safety and Quality Committee • Medical Executive Committee • Medical Peer Review Committee • Surgical Leadership Committee
2014-present	Clinically Integrate Network of Eastern Connecticut (CINECT)
2011-2012	ECHN PHO President • ACO Development Committee
2010	ECHN PHO Vice President

Hospital Affiliations

1997-present	Active Staff, Eastern Connecticut Health Network Manchester, CT
1993-1997	Active Staff, Manchester Memorial Hospital Manchester, CT

Academic Appointments

2011- Present	Assistant Professor of Clinical Obstetrics and Gynecology at the University of New England College of Osteopathic Medicine
1988-1989	Research Assistant, Department of Obstetrics and Gynecology University of Miami School of Medicine Dr. Mary J O' Sullivan
6/1986	Research Assistant, Department of Pediatrics

	University of Miami School of Medicine Dr. Donald Vernon
6/1985-8/1985	Cardio-Pulmonary Technician Florida Medical Center, Ft Lauderdale, FL Randy Guessetto - Director
1982-1984	Research Assistant, Department of Pulmonary Medicine University of Miami School of Medicine Lee Frank, PhD, MD
6/1982-9/1982	Volunteer Emergency Room Florida Medical Center, Ft. Lauderdale, FL

Memberships

2001-2002	President, Greater Hartford Obstetrical and Gynecological Society
1993-Present	American College of Obstetricians and Gynecologists Fellow
1993-Present	Hartford County Medical Society
1993-Present	New England OB/GYN Society

Special Courses

- Colposcopy and Laser Certification
- Neonatal Resuscitation Certification

Licensure/Certification

Licensure: Connecticut
Certification: Board certified December 1995
Honors and Awards: Resident Research Award May 1991, 1992, 1993
American Lung Association Pulmonary Summer Scholarship: July 1986

Publications

Frank, L., Lewis, P., Garcia-Pons, T: Intrauterine growth-retarded rat Pups show increased susceptibility to pulmonary oxygen toxicity. Pediatric Research Vol. 19 No.3, 1985. Pp.569-574

Frank, L., Lewis, P. Sosenko, I: Dexamethosone stimulation of fetal rat Lung antioxidant enzyme activity in parallel with surfactant Stimulation. Pediatrics Vol. 75 No. 3, March 1985. Pp569-574.

Publications Continued

Sosenko,I., Lewis, P., Frank, L: Metyrapone delays surfactant and Antioxidant enzyme maturation in developing rat lung. Pediatric Research Vol.20 No 7, 1986. Pp672-675.

Vernon, D., Holzman,B., Lewis, P: Respiratory failure in children with AIDS-related complex. Pediatrics Vol. 82 No.2, August: 1988. pp.223-228.

Lashgari, M., Lewis, P.: A Comparison of cold knife, co2 laser and Electrosurgical Loop Conization in the treatment of cervical Intraepithelial Neoplasia. Journal of Gynecologic Surgery 1994.

Abstracts

Frank, L., Lewis, P., Sosenko, I: Dexamethasone stimulates rat lung Antioxidant enzyme activity in parallel with surfactant stimulation. Pediatric Research 18; 1771 A.1984.

Frank, L., Neriishi, K, Lewis, P., Sio, R: Prolongation of tolerance to Pulmonary oxygen toxicity by castration of young male rats. Pediatric Research 18:137 A. 1984.

Sosenko, I., Lewis, P., Frank, L: Metyrapone delays maturation of fetal lung Surfactant and antioxidant enzyme: are both under endogenous Glucocorticoid control? Pediatric Research 19: 1839 A. 1985.

Vernon, D., Lewis, P., Holzman, B: Acute respiratory failure in children With Acquired Immune Deficiency Syndrome: Causes and Implications. Critical Care Medicine 15: No 4, April 1987, p412. Presented at the 16th Annual Scientific and Educational Symposium of Society for Critical Care Medicine, May 26-29, 1987, Anaheim, Ca.

Scorza, W., Lewis, P., Vintzileos, A: Qualitative Physical and Chemical Changes of Infected Amniotic Fluid in an vitro study. Presented at The Society of Perinatal Obstetricians Meeting. Orlando, FL, February 1992.

Lewis, P., Morel, M., Scotti, R: Heterotopic intrauterine and Tubal Ectopic Pregnancy complicated by Pulmonary Embolus. JOURNAL Of Reproductive Medicine Vol.39 May 1994 No.5 pp 417-418.

Lewis, P., Mendelovici, R., Scotti, R: A Case Report of Invasive Mole with Uterine Rupture. Journal of Gynecologic Surgery Vol.10 No.2 pp 89-91.

EXHIBIT 27 – CURRICULUM VITAE: TENET

Erik G. Wexler

[redacted]

Seasoned leader with more than 20 years of broad executive experience spanning clinical and non-clinical operations, business development, physician recruitment, community outreach and fund raising. Distinguished record in clinical quality, physician relations, customer service, organizational development, strategy and financial outcomes. Known for having a strong passion for excellence, integrity and accomplishment, while maintaining values of caring, respect and teamwork.

PROFESSIONAL EXPERIENCE

TENET HEALTHCARE – New England Region, Southborough, Massachusetts
President — **October 2013 – Present**

VANGUARD HEALTH SYSTEMS – New England Region, Southborough, Massachusetts
President — **April 2012 – October 2013**

SAINT VINCENT HOSPITAL / VANGUARD HEALTH, Worcester, Massachusetts
President & Chief Executive Officer — **July 2011 – October 2013**

Vanguard Health Systems (NTSE: VHS), Nashville, TN, is a Fortune 500 company with over $6.5 billion of net revenue in acute, post acute and ambulatory services. With 28 hospitals located in five regions across the country, the company has over 44,000 employees. The New England Region currently has three hospitals located in Worcester, Framingham and Natick Massachusetts. Two additional hospital acquisitions, Waterbury Hospital and Bristol Hospital, are nearing completion in Connecticut. With these acquisitions complete, the region will have over $1.5 billion of net revenue and 8,000 employees. Mr. Wexler initiated an affiliation with Tufts Medical Center, Boston, MA upon his appointment to the presidency of the New England Region and is in the final stages of completing that transaction. In addition, as part of the Accountable Care Act, the first COOP Insurance program in Massachusetts, MinuteMan Health, was formed under his leadership in conjunction with Tufts Medical Center and will launch in January 2014.

Saint Vincent Hospital is a 348 bed tertiary teaching hospital with annual net operating revenue of $400 million, 2,000 employees and 1200 members of the medical staff. It is the flagship hospital of for-profit Vanguard Health, Nashville, TN. The Hospital has 120 residents in various specialties and maintains independent residency programs and an academic affiliation with the University of Massachusetts School of Medicine. The hospital was recognized as a Thompson Reuters Top 100 Hospital in 2011, 2012, and 2013 and a Thompson Reuters Top 50 Hospital for Cardiovascular Care in 2012 and 2013. Major service lines for the institution include the Center for Musculoskeletal Services, Center for Cancer Care, and the Center for Heart & Vascular Services. As one of the first hospitals in Massachusetts to perform open heart surgery, the institution is known for outstanding clinical outcomes in cardiovascular care. Recognized as a "high value" provider, high efficiency and superb quality/safety measures exceed state benchmarks allowing the institution to be a "Tier 1" provider with every commercial payer in the market.

NORTHWEST HOSPITAL & LIFEBRIDGE HEALTH, Baltimore, Maryland
President & COO, Northwest Hospital & Senior Vice President, LifeBridge Health — **Jan. 2004 – June 2011**

LifeBridge Health, "A" rated by Standard and Poors and "A2" by Moody's, is the fourth largest health system in Maryland with over $1.2 billion in net revenue, three hospitals with a total of more than 800 beds, long-term care, a nursing home, 7,000 employees, 200 employed physicians and teaching affiliation with Johns Hopkins School of Medicine. This fully integrated system has shared clinical programs in Brain and Spine, Oncology, Behavioral Health, and Cardiovascular Care. As Senior Vice President, and one of four top executives of LifeBridge Health, leads Northwest Hospital as its President and has corporate oversight of the following divisions: Capital Improvements (construction design / development and real estate), facility services (engineering, clinical engineering, protective services, transportation, and environmental services), Marketing/Outreach, and the Wellness Division (for-profit entities: LifeBridge Health & Fitness and LifeBridge Health Physical Therapy / Sports Medicine).

Northwest Hospital is a 246 bed general acute care hospital with net operating revenue of $220 million, 1,700 employees and 700 members of the medical staff. Inpatient services include medical/surgical, oncology, heart care, intermediate care, intensive care, sub-acute, psychiatry, and a fully dedicated hospice unit. Other major services include Advanced Minimally Invasive Surgery, Wound Care / HBOT, Cancer Care, Breast and Bone Health, Cardiac Rehabilitation, Pain Management, Women's Wellness, Sleep Disorders, and Physical Rehabilitation.

MIDSTATE MEDICAL CENTER, Meriden, Connecticut

Executive Vice President & Chief Operating Officer **Jan. 2000 - Jan 2004**

MidState Medical Center, a wholly-owned subsidiary of Hartford Health Care, is a 140 bed community acute care hospital with net operating revenue of approximately $140 million, 1,000 employees and 300 members of the medical staff. Reporting to the President & CEO, responsible for the operations of the hospital's two campuses, with direct oversight of clinical and non-clinical departments, managed care contracting, strategic business development, physician relations, and community outreach. Also served as Vice Chairman of the Hospital's Physician-Hospital Organization and responsible for oversight of two subsidiaries; The MidState VNA & Hospice and Meriden Imaging Partners.

GREATER WATERBURY HEALTH NETWORK & WATERBURY HOSPITAL, Waterbury, CT

Vice President, Business Development & Community Relations **1996 - 2000**
Vice President, Development and Community Relations **1992 - 1996**

Waterbury Hospital is a 350-bed teaching hospital (affiliated with the Yale University School of Medicine). Reporting to the President & C.E.O. of the health system, had oversight of various Hospital departments and 6 subsidiaries while responsible for coordinating the growth, development and marketing of the Corporation. Initial responsibilities included philanthropic support, marketing and the overall improvement of public opinion, government relations, and market share growth. Oversaw all external relations departments, including the Office of Development, Community Health Services, Volunteers, Department of Public Affairs, and Telecommunications. Also served as the Chairman of the Board of Access Rehab Centers and Home Care Professionals.

UNIVERSITY OF HARTFORD, West Hartford, CT

Director of Development / Executive Director, The Associates **1989-1992**
Associate Director of Development **1988-1989**
Presidential Administrative Intern and Development Officer **1985-1987**

As Director, responsible for overseeing all annual and capital fund raising activities, development-related public affairs, Institutional Advancement budgets, and philanthropic information systems. Total fund raising exceeded $7 million per year. In addition, managed the The Associates which consisted of 400 Hartford-area businesses that contribute to the University and sponsor two major fund raising events per year.

EDUCATION

Master of Business Administration
University of Hartford
West Hartford, CT 06117

Bachelor of Arts in Sociology
University of Hartford
West Hartford, CT 06117

AFFILIATIONS

United Way of Central Massachusetts, Worcester, MA
Campaign Cabinet, 2012 to 2013
Campaign Chairman 2013 to present
The Schwartz Foundation, Boston, MA
Annual Dinner Chairman, 2013
Anna Maria College, Paxton, MA
Member, Board of Trustees, 2012 - present
American Hospital Association, Regional Policy Board
2008 to 2011
Maryland Hospital Association, Women & Minority Business Task Force
Chairman, 2008 to 2011
Maryland Hospital Association, Committee on Government Relations
Member, 2005 to 2011

Stevenson University, Owings Mills, Maryland
Member, President's Advisory Board, 2010 - 2011
Howard S. Brown School of Business, Stevenson University
Member, Advisory Board, 2009 to 2011
The George Washington University School of Medicine & Health Sciences
Executive-In-Residence, 2007 to present
Baltimore County Work Force Development
Director, 2005 to 2011
Healthcare Workforce Sub-committee, Baltimore County Work Force Development
Chairman, 2007 to 2011
Owings Mills Corporate Round Table
Chairman, 2008 to 2011
Workers' Compensation Commission Advisory Board, State of Connecticut
Director, 1997 – 2004
Governor's Prevention Partnership
Vice Chairman, 1998 - 2004
Director, 1995 - 2004
The United Way of Central Naugatuck Valley
Chairman, 2001 – 2004
Vice Chairman, 1999 – 2001
Director, 1994 - 2004
Connecticut Hospital Association, Committee on Government
Member, 1997 - 2004
Meriden Chamber of Commerce
Director, 2001 – 2004
BankBoston Regional Advisory Board
Director, 1995 - 2000
Mattatuck Museum
Director, 1998 - 2000
The Salvation Army
Secretary and Director, 1995 - 1998

Mark R. Montoney, MD, MBA

[redacted]

PROFESSIONAL PROFILE

Results-oriented senior physician executive with proven experience in clinical quality performance improvement, patient safety, clinical resource management, research and innovation, medical education and physician leadership development. Demonstrated record of program development, driving successful change in large, complex healthcare organizations, resulting in local, state and national hospital system recognition. Ability to work effectively with a senior leadership team in developing strategy and connecting to a broad medical staff and other clinicians, across multiple clinical sites to implement and achieve organizational goals.

PROFESSIONAL EXPERIENCE

CHIEF MEDICAL OFFICER **2013 TO PRESENT**
Tenet Healthcare Corporation, Dallas, Texas

Started position with Tenet Healthcare in October 2013 as Corporate Chief Medical Officer. System-wide role and responsibilities include leadership of patient safety, clinical risk management, clinical quality improvement, organizational accreditation, pharmacy and clinical research. Tenet is an integrated healthcare delivery system operating 80 acute care hospitals and over 190 ambulatory facilities across the United States.

EXECUTIVE VICE PRESIDENT AND CHIEF MEDICAL OFFICER **2009 TO 2013**
Vanguard Health Systems, Nashville, Tennessee

Assumed position in January, 2009, with responsibilities including system leadership for clinical quality improvement, patient safety, physician alignment strategies and value-based health care delivery. Member of the executive leadership team with direct reporting to the President and Chief Operating Officer. Vanguard Health Systems operates 28 acute care hospitals and multiple ambulatory facilities across 5 states.

Program development and key achievements:

- Established the Vanguard Quality Council that served to drive organizational performance in clinical core measures, readmission rates, hospital acquired conditions and severity adjusted mortality. Statistically significant improvement noted in all indicators including top quartile national performance for core measures.

- Led the high reliability organization initiative resulting in a reduction of serious safety events by 76% from baseline over a 3 year period. In addition, central line infection rates decreased by 13% and hospital acquired pressure ulcers were reduced by 49% over this same time period. Realized a 20% reduction in annual excess malpractice insurance premium with cost savings of $1.1 M, due to improvement in patient safety.

- Developed a system-wide clinical council in 12 services lines focused on reduction of unnecessary clinical variation. This resulted in measureable improvement in clinical outcomes with lower cost, highlighted by $5.2 M cost savings in critical care in fiscal year 2013.

- Established a telemedicine model in several markets through the eICU in San Antonio, Texas, and tele-radiology services in Phoenix, Chicago and Detroit. The latter initiative enabled

significant reductions in clinical study turnaround times, staffing, subsides, 3rd party vendor expenses and improved quality with cumulative economic value of $7.2M in fiscal year 2013.

- Advanced palliative care model across Vanguard markets, highlighted by an ICU – Palliative Care project that resulted in a 6 fold increase in change of goals of care and code status with subsequent increase in hospice referrals. Also, a 30% relative reduction in 30 day readmissions was realized in this patient population.

- Established hospitalist services in all markets, highlighted by $3.3 M in cost savings generated through a system level agreement with Sound Physicians in Phoenix and San Antonio.

- Established Physician Leadership Councils in all Vanguard facilities enabling strategic planning development between hospital executives and medical staff leadership.

- Provided system clinical leadership in the establishment of five regional CMS ACO initiatives, including a Pioneer ACO in Detroit. The Pioneer ACO included 224 participating physicians and 18,455 attributed beneficiaries; the Detroit effort was one of the 13 pioneers with a successful first year that including cost savings of $8 M.

SYSTEM VICE PRESIDENT AND CHIEF MEDICAL OFFICER **2005 TO 2008**
OhioHealth Corporation, Columbus, Ohio

Appointed in July 2005 to provide leadership of system-wide clinical quality, patient safety, clinical resource utilization, clinical research and innovation, medical education and physician leadership development for OhioHealth Corporation, a $ 2 billion net revenue healthcare system, headquartered in Columbus, Ohio. OhioHealth is the leading provider of healthcare in the central Ohio region and is comprised of 8 member hospitals, 8 affiliate hospitals and 19 ambulatory sites. Member of the senior leadership team with direct reporting to the system Chief Operating Officer.

Program development and key achievements:

- Established the OhioHealth patient safety program, resulting in a reduction in adverse drug events of 57% and a reduction of sentinel events of greater than 50% over three years. This has contributed to system excess malpractice insurance premium reductions of 23% over the past two years.
- Led performance improvement in clinical quality, as assessed through CMS hospital core measures and HCAHPS, resulting in OhioHealth being ranked 10th in the nation among large hospital systems. (Source: *The Joint Commission Journal on Quality and Patient Safety,* June 2008)
- Responsible for launch of the OhioHealth Research and Innovation Institute, which supports over 500 ongoing clinical trials and established a technology transfer office which supports OhioHealth clinicians in the commercialization and product development process.
- Established the Clinical Excellence Committee, dedicated to driving evidence based, best practice standards across central Ohio campuses, resulting in cost savings of $4.1 million in fiscal year 2008.
- Redesigned the medical staff peer review structure in central Ohio hospitals with significant process improvement consistent with The Joint Commission standards.
- Established the OhioHealth Physician Leadership Academy, a leadership development program for physicians, consisting of a core curriculum and individual coaching modules. In the past two years, over 200 physicians have attended the Academy quarterly education sessions.
- Member of the senior leadership team responsible for launching Dublin Methodist Hospital in January 2008, a new 100 bed state-of-the-art digital acute care facility, which employs a full suite of integrated advanced clinical information technology applications, resulting in Dublin

being named one of the "most wired" hospitals in America. Currently involved with standardizing these applications across the other system hospitals.
- Executive leadership of the OhioHealth eICU program which provides centralized monitoring of 109 critical care beds across the system and has contributed to a 10.5% reduction in severity adjusted mortality rate in the ICU population.
- Development of an evolving state-wide stroke network program, employing telemedicine technology in a hub and spoke model to facilitate transfer and treatment of appropriate stroke patients to Riverside Methodist Hospital.
- Executive leadership of the OhioHealth Breast Health Institute, a system program, that has resulted in a 10 day reduction in days to detection (screening to final pathology) for breast tumor patients.
- Launched the OhioHealth Clinical Documentation Improvement program in the Fall 2007 in response to the CMS MS-DRG program. This initiative has led to a $1.9 million favorable financial impact through the end of fiscal year 2008 by improved physician documentation, as it relates to the new coding system.
- Launched a value-based PHO contracting model in collaboration with leaders from a 2,000 physician IPA (Medical Group of Ohio), aligning a physician pay for quality program with an OhioHealth associate health and wellness initiative. This has resulted in an increase in performance on preventive screening measures for the 16,000 OhioHealth employees and dependents and initiated efforts to achieve clinical integration.

VICE PRESIDENT, QUALITY AND CLINICAL SUPPORT **2000 TO 2005**
RIVERSIDE METHODIST HOSPITAL, COLUMBUS, OHIO

Primary responsibilities included the development of the Institute for Clinical Excellence at Riverside, committed to supporting best practice models of patient care with attention to clinical quality, patient safety, and clinical care coordination. Riverside is the 985 bed tertiary care flagship hospital of the OhioHealth system. Departmental responsibilities included quality outcomes management, clinical-fiscal informatics, and pain management and palliative care.

Program development and key achievements
- Established 109 pre-printed orders and 29 clinical pathways, standardizing patient care upon evidence-based medicine.
- Founded and chaired the Riverside Patient Safety Council and established Patient Safety Rounds and Work Plan as organizational priorities. Reduced adverse drug events due to opioids by greater than 40%.
- Established the Pain Management & Palliative Care Service resulting in hospital cost savings of approximately $434,000 over 18 months and improvement of pain scores better than target.
- Provided support for clinical process improvement initiatives resulting in achievement of better than target performance in 10 of 14 OhioHealth clinical quality indicators in fiscal year 2004.
- Founded the Hospital Medicine Council in April 2002 which evolved to the Medicine Clinical Operations Council. Established Co-Director Hospital Medicine positions, focused on establishing infrastructure support for hospitalist physicians. This enabled process improvement initiatives resulting in improved efficiency and quality of patient care.
- Served the Medical Executive Committee Redesign and Implementation Team, involved in creating a new infrastructure to support a more effective medical staff function and integration with hospital operations.
- Executive sponsor for launching the Riverside New Clinical Technology Committee; a physician driven forum designed to evaluate cutting edge technology in a clinically and fiscally responsible manner.
- Reduced managed care denials rate from 4.1% to 2.0% over two years through process improvement initiatives, resulting in a favorable net revenue impact of $5.3 million.

VICE PRESIDENT, PHYSICIAN CONSULTING **1999 TO 2000**
OHIOHEALTH SYSTEM SERVICES, COLUMBUS, OHIO

Developed and maintained clinical documentation programs in participating OhioHealth hospitals, resulting in documentation improvements to support accurate DRG coding. Developed documentation templates relevant to outpatient clinical areas that resulted in improved coding and compliance. Led the Diabetes Disease Management Team at OhioHealth Group, the system PHO, in improving the quality of care of diabetic patients across the continuum of care and developed a Diabetes Management Program that was utilized across the system. Provided consultative support in the development of documentation programs in hospitals in Pensacola, Florida, Columbia, South Carolina and Cleveland, Ohio.

ASSOCIATE MEDICAL DIRECTOR, PRIMARY CARE **1998 TO 1999**
GRANT MEDICAL CENTER/RIVERSIDE METHODIST HOSPITAL, COLUMBUS, OHIO

Provided physician support for the clinical documentation management program, resulting in a cross campus improvement in documentation and DRG coding. Served as Chairman for the Primary Care Clinical Process Improvement Committee on both campuses, involved in process improvement initiatives including implementation of a discharge communication process. Supported peer review processes in primary care at both the Grant and Riverside campuses.

REGIONAL PHYSICIAN MANAGER **1996 TO 1998**
BIRMAN & ASSOCIATES, INC., COOKEVILLE, TENNESSEE

Part-time position involved with leadership of medical staff at Knox Community Hospital (Mt. Vernon, Ohio) in regard to chart documentation as applied to DRG coding and hospital reimbursement. Developed a documentation educational program for the staff, resulting in improvement in the hospital case mix index. This contributed to Knox Community Hospital being ranked in the Solucient top 100 hospitals in the United States in 1997. Developed a physician utilization profile program for the KCH medical staff that was implemented in 1998.

MEDICAL DIRECTOR **1989 TO 1999**
HEALTHCARE CENTER AT THE FORUM RETIREMENT COMMUNITY, COLUMBUS, OHIO

Founding Medical Director of a 60 bed extended care facility. Developed policies and procedures for the facility while providing direction for the nursing and ancillary staff, as well as delivering direct patient care. Provided direction in the development of a 25 bed special care unit for patients with Alzheimer's disease.

ATTENDING PHYSICIAN
KNIGHTSBRIDGE INTERNAL MEDICINE & CARDIOLOGY INC., COLUMBUS, OHIO **1999 TO 2000**

Part-time member of a thriving group practice, delivering office-based care to general internal medicine and geriatric patients.

SENIOR PARTNER **1986 TO 1999**
CENTRAL OHIO MEDICINE, COLUMBUS, OHIO

Managing partner in a high volume internal medicine practice, directing 18 full-time employees. Developed a large practice with a focus on geriatric patients. Involved in the integration of the practice into Central Ohio Primary Care, Inc., (COPC), a 180-member primary care group. Served COPC as Chairman of the Medical Records Committee.

CLINICAL TEACHING EXPERIENCE

Teaching Faculty, Riverside Methodist Hospital Community Medicine 2000 to 2005

Clinical Assistant Professor of Medicine, the Ohio State University College of Medicine
1987 to 1996

Teaching Attending, Riverside Methodist Hospital Internal Medicine Residency Program
1985 to 1996

ADDITIONAL EXPERIENCE

- Adjunct Faculty Supervising PhD candidate, Central Michigan University, Mount Pleasant, Michigan – 2004
- MBA Coach, Franklin University, Columbus, Ohio 2004
- Examiner, Malcolm Baldrige National Quality Award (MBNQA) 2002 – 2003
- Examiner, Ohio Award for Excellence (OAE) 2001 – 2002
- Intermountain Health Care, Advanced Training Program in Healthcare Delivery Improvement, Salt Lake City, Utah – 2002
- OhioHealth Facilitator, The Quality Advantage Training Program (TQA) 2001 – 2002

EDUCATION / TRAINING

Regent University, Virginia Beach, Virginia 1997 to 2001
M.B.A.

Riverside Methodist Hospital, Columbus, Ohio 1982 to 1986
Internal Medicine Resident (1982 – 1985)
Chief Medical Resident (1985 – 1986)

University of Cincinnati College of Medicine, Cincinnati, Ohio 1978 to 1982
M.D.

Case Western Reserve University, Cleveland, Ohio 1974 to 1978
B.A., Psychology – Graduated Magna Cum Laude, elected to Phi Beta Kappa

BOARD CERTIFICATION

Recertified, Geriatric Medicine	2004
Certified, Added Qualifications in Geriatric Medicine	1994
Certified, American Board of Internal Medicine	1985

BOARD AND PROFESSIONAL AFFILIATIONS

- Past Board Chairman, Ohio Partnership for Excellence (State Quality Program)
- Member, American College of Physician Executives
- Past Board Member, Tennessee Center for Performance Excellence (State Quality Program)
- Board Member, Percuvision, Inc.
- Chair, Quality Committee, Federation of American Hospitals
- Member, Clinical Advisory Committee, Heritage Innovation Fund

HAROLD (TRIP) PILGRIM
[redacted]
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PROFILE

Proven health care business professional with executive and senior management experience in a variety of corporate and service capacities. Strong leadership, sales and marketing skills leveraged in roles that include operations, integrated delivery systems, management consulting, mergers and acquisitions, co-founder of a technology start-up, and health care investment banking.

EMPLOYMENT HISTORY

Tenet Healthcare — Dallas, TX

Tenet Healthcare Corporation, a leading healthcare services company, through its subsidiaries operates 80 hospitals, 193 outpatient centers and Conifer Health Solutions, a leader in business process solutions for healthcare providers serving more than 700 hospital and other clients nationwide.

October 2013 to present
Senior Vice President, Development
Oversees the company's strategic transactions, including acquisitions, divestitures and market development

Vanguard Health System — Nashville, TN

Vanguard Health Systems owns 28 general acute care hospitals in Illinois, Arizona, Texas, Michigan and Massachusetts.

Employed by Vanguard since **October 2001:**

July 2009 to September 2013
Chief Development Officer
Responsible for managing the operations of the mergers & acquisition function of the company.

- Company has grown from 15 to 28 hospitals and revenues have increased from $3 billion to $6.5 billion pro forma since 2009.
- Acquisitions include the Detroit Medical Center (8 hospitals, $2 billion in revenue), Valley Baptist Health System (2 hospitals, $400 million in revenue), and two hospitals out of the Resurrection System in Chicago.

Baptist Health System — San Antonio, TX

Baptist Health System is owned by Vanguard Health Systems

October 2005 through June 2009
President and Chief Executive Officer
Responsible for leading this urban based, comprehensive delivery system:

- 5 general acute care hospitals
- 1,700 licensed beds
- $950 million in net revenue
- 6,300 employees
- 7 OP imaging centers
- 2,400 medical staff membership

January 2003 to October 2005
Regional Vice President – Business Development
Responsible for new business development, marketing, communications, government relations, public relations,

physician recruiting, and community outreach.

October 2001 to December 2002
Vice President – Development/Investor Relations
Key member of corporate team responsible for acquisitions in new markets and for business development in existing Vanguard markets. Also initiated Vanguard's Investor Relations function, subsequent to the issuance of $300 million in public debt in July 2001.

VelocityHealth Capital — Nashville, TN

January 2001 to Oct 2001
VHC operates a specialty investment bank that assists companies with creating, building, and funding promising health care and technology opportunities. Advisory services include private equity assistance, merger & acquisitions, strategic planning and capital formation consulting.

Chief Development Officer
Responsibilities include client acquisition, developing strategic partnerships, and managing private equity, M&A and consulting engagements.

Highlights
- Established partnership with Communitech, Inc. in first month of employment.
- Coordinated Co-Sponsorship of the 10th Annual Innovative Drug Conference
- Successfully engaged early stage health care CRM company on retainer plus success fee in first month of employment.

Phyve Corporation (*www.phyve.com*) — Nashville, TN

Formerly Digital Medical Systems, Inc.
Formerly Vger Technologies, Inc.
April 1997 to August 2000

An eHealth enabler, Phyve Corporation provides technology solutions and services required by healthcare provider and payer organizations to enable the secure and efficient delivery and exchange of healthcare applications and information via the Internet.

Co-Founder & Senior Vice President, Corporate Development
Primary responsibilities included developing new business opportunities, financing activities, corporate strategic planning, financial oversight and establishing and managing strategic relationships.

Highlights
- Key point individual on early strategic sales efforts
- Raised $26 million in private equity capital over three years
- Negotiated two exclusive strategic partnership agreements
- Participant in CHIM working group to identify Federal lobbying initiatives for increased information technology development in health care
- Presented corporate overview at the annual Warburg Dillon Read 2000 equity conference
- Led the acquisition of Digital Medical Systems by Vger Technologies
- Recruited CFO, Corporate Controller, VP-Marketing/Product Development & VP-Emerging Technologies
- Co-coordinated company's participation at the annual HIMSS exhibitor conferences in 1999 and 2000
- Active participant in CHIM, HIMSS and the Nashville Health Care Council

OrNda Healthcorp — Nashville, TN

(Acquired by Tenet Health Systems 1/97)
OrNda Healthcorp, a $400 million revenue company at the time of its inception in 1992, was a $3 billion hospital management company at the time of the sale to Tenet.

Assistant Vice President, Acquisitions and Development
January 1996 to April 1997
Primary job functions included lead generation and development, proposal writing and managing the transaction processes to closing relating to:

- Hospital acquisitions
- Physician joint ventures
- Physician group practice development

Highlights
- Part of acquisition team that grew the Company from 46 to 55 hospitals
- Negotiated partnerships with large not-for-profit hospital system in Texas
- Gave multiple presentations to various medical staffs on Stark II and the benefits of group practice formation
- Member of the Public Relations and Legislative sub-committees of the Federation of American Health Systems

Director of Investor Relations
September 1995 to May 1996
Responsible for managing the investor relations function, including:

- Annual report production
- Quarterly earnings releases
- Press releases
- Communicating with sell-side and buy-side analysts
- Presentations for road shows and investor conferences
- Secondary common stock offering in November 1995

Highlights
- Part of road show team for $200 million secondary stock offering
- Led development of first corporate web site
- Active member of the National Investor Relations Institute

The Medstat Group/Inforum Nashville, TN
February 1995 to September 1995

Product Director
Responsible for designing and developing new market-focused decision support/information products for healthcare providers and managed care organizations, including:
-- Concept development
-- Managing the product development process
-- Led product teams of software applications engineers, programmers and other development staff

Ernst & Young LLP Birmingham, AL
August 1986 to February 1995

Manager, South Region Health Care Consulting Group
Managed and conducted consulting engagements including strategic planning, mergers and acquisitions, financial feasibility studies, software training, and third-party reimbursement assistance for a variety of healthcare clients throughout the southeastern United States. Additionally, gave recruiting presentations and conducted on-campus interviews for the region.

Current or Past Industry Affiliations, Community Organizations & Other Appointments

Current Board Chair, Baptist Health System, San Antonio, TX
Current member, Board of Directors, The Federation of American Hospitals
Current Chair, Legislative Sub-committee, The Federation of American Hospitals
Co-Chair, Valley Baptist Health System
Council on Policy Development, Texas Hospital Association, 2008-2009
Board member, Texas Hospital Association, 2008-2009
Former Chair and current board member, Greater San Antonio Hospital Council

Member, Governor Rick Perry's Task Force on Medicaid Reform, 2005
Member, Texas Hospital Association's Special Committee on Medicaid
Member, Greater San Antonio Chamber of Commerce's Health Care and Bioscience Subcommittee
Past Chair and, Public Relations Subcommittee of Federation of American Hospital Systems
Former Trustee, VIA Metropolitan Transit Authority

EDUCATION

Masters of Business Administration, 1986
Concentrations in *Finance* and *Marketing*
Vanderbilt University, Nashville, Tennessee

Bachelor of Arts, Political Science, 1983
Vanderbilt University, Nashville, Tennessee

CURRICULUM VITAE

KELVIN A. BAGGETT, M.D., M.P.H., M.B.A., F.A.C.P., F.A.C.H.E.

OFFICE ADDRESS

[redacted]

TELEPHONE NUMBERS

[redacted]

HOME ADDRESS

[redacted]

CERTIFICATIONS

Diplomat, American Board of Internal Medicine

MEDICAL LICENSURE

2002-present	North Carolina
2006-present	Tennessee

EDUCATION

1989-1993	B.S.	The University of North Carolina at Chapel Hill Chapel Hill, North Carolina
1994-1999	M.D.	East Carolina University School of Medicine Greenville, North Carolina
2002-2006	M.B.A.	The Fuqua School of Business Duke University, Certification in Health Sector Management Durham, North Carolina (Leave of Absence from 2003-2005 to complete fellowship training)
2003-2005	M.P.H.	The Johns Hopkins Bloomberg School of Public Health Baltimore, Maryland

POSTGRADUATE TRAINING

1999-2000	Intern, Department of Medicine, Yale University School of Medicine, Yale-New Haven Hospital
2000-2002	Resident, Department of Medicine, Yale University School of Medicine, Yale-New Haven Hospital
2002-2003	Fellow, Department of Medicine, Duke University Medical Center
2003-2005	Fellow, The Robert Wood Johnson Clinical Scholars Program, Department of Medicine, The Johns Hopkins Hospital
2005-2006	Fellow, Department of Medicine, Duke University Medical Center
2005-2006	Fellow, Duke Clinical Research Institute, Duke University Medical Center

PROFESSIONAL EXPERIENCE

Summer 2002 Consultant, Waterbury Hospital Health Center

2006-2007 Strategic Business Consultant, Hospital Corporation of America (HCA)
Developed market strategies for service line and product line development
Developed outpatient service line definitions based on diagnostic codes in order to quantify ambulatory volumes and financial performance
Provided strategic guidance on ED and OR efficiency
Worked with physicians to create and implement strategies for improved alignment
Supported assessments related to clinical asset liquidation

2007-2009 Consulting Associate, Duke University Medical Center

2007-2009 Chief Operating Officer & VP, Clinical Strategy, Clinical Services Group (HCA)
Responsible for the development and execution of clinical strategies for the enterprise, which spanned more than 160 acute care hospitals, more than 125 outpatient centers and physician practices
Led senior executives in the development and execution of clinical strategies that pertained to clinical performance improvement, provider certification, patient safety, physician engagement, commercial payor contract negotiation and the implementation of a system wide electronic health record
Served as the central clinical point of contact for all national managed care agreements that included clinical performance, risk based arrangements
Provided daily leadership of approximately 100 employees
Led in the development of management tools to evaluate and improve clinical performance
Development of the HCA "Getting to Green" Strategy that resulted in improvements in aggregate core measure clinical performance
Led the development and execution of a strategy to improve the patient's experience (HCAHPS)

2009-2012 Chief Medical Officer & SVP of Clinical Quality, Tenet Healthcare
Responsible for improving the quality, safety and efficiency of care provided throughout the system, which includes 49 acute care hospitals and more than 90 outpatient centers
Created the Clinical Innovation Award to foster and recognize significant advancements in the delivery of patient care

Oversight of the system wide implementation of an electronic health record
Liaison between the health care system and medical community

2012-2013 Chief Medical Officer & SVP of Clinical Operations, Tenet Healthcare
Responsible for setting the system wide clinical strategic priorities
Responsible for improving the quality, safety, efficiency and value of care provided throughout the system, which includes 49 acute care hospitals and more than 120 outpatient centers
Responsible for identifying opportunities to reduce clinical variability and waste and for designing and executing strategies to capture that opportunity
Responsible for clinical integration across the full continuum of care
Oversight of the system wide implementation of an electronic health record
Liaison between the health care system and medical community

2013 - Present Chief Clinical Officer & SVP of Clinical Operations, Tenet Healthcare
Member of the nine member Executive Leadership Team
Accountability for clinical operations performance, which includes quality, safety, service and reducing clinical waste and variability within 78 acute care hospitals, 170 outpatient centers and 5 health plans
Serve in a co-leadership model with the President, Hospital Operations (who also has responsibility for ambulatory care and physician services) to design and execute strategies that enhance Tenet's position as a leading value based provider of care
Create a clinical leadership infrastructure for physicians, Tenet health plans, hospitals and outpatient facilities
Provide leadership for clinical technology implementation, integration of care across the continuum and care innovation, including oversight for how and where we position Tenet strategically and how we deploy capital
Serve as a key external representative and spokesperson for the system
Direct reports include: Tenet's Chief Medical Officer (Acute Care), Chief Medical Officer, Physician Resources, Chief Medical Officer, Health Plans, National Director of Clinical Performance Excellence, Vice President, Care Experience
Co-Chair of the following Executive Committees: Analytics; Performance Excellence

AWARDS, HONORS, AND MEMBERSHIPS IN HONORARY SOCIETIES

1989-1993 Merit scholarship, Herbert Lehman Scholarship Award, NAACP Legal Defense and Educational Fund
1991-1993 Merit scholarship, The Wellman Corporation
1994-1999 North Carolina Board of Governors Medical Scholarship (Full scholarship covering medical school tuition, fees and annual stipend)
2002-2003 Merit Scholarship, The Fuqua School of Business
2003-2005 Health Disparities Scholar, National Center on Minority Health Disparities, National Institutes of Health
2004-2005 Merit scholarship, The Johns Hopkins Bloomberg School of Public Health

2005-2006	Merit scholarship, The Fuqua School of Business
2011	Awarded as "40 under 40" honoree – Dallas Business Journal
	Awarded as Minority Business Leader – Dallas Business Journal
2012	Top 25 Minority Executives – Modern Healthcare
	Awarded as Top 50 Most Influential Physician Executives – Modern Healthcare #6
2012	Trailblazer Alumni Award – Fuqua School of Business, Duke University
2012	Acknowledged in the 100 Hospital and Health Systems CMO's-Becker's Healthcare
2013	Awarded as Top 50 Most Influential Physician Executives – Modern Healthcare #18
2014	Awarded as Top 25 Minority Executives in Healthcare – Modern Healthcare
2014	Top Blacks in Healthcare – BlackDoctor.org

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

2000-Present	Member, American College of Physicians
2006-Present	Fellow, American College of Physicians
2011-Present	Member, American College of Healthcare Executives
2012-Present	Fellow, American College of Healthcare Executives

RESEARCH ACTIVITIES AND INTERESTS

2002-Present Utilizing operational techniques to evaluate and improve clinical performance
Reducing variation in the secondary prevention of cardiovascular disease
The value and impact of Pay for Performance programs
Structuring Health Care Delivery to Promote Quality
Mentors/Co-Investigators: Drs. Neil R. Powe, Haya Rubin, Roger Blumenthal (Johns Hopkins University School of Medicine) and Kevin Schulman (Duke University School of Medicine)

PUBLICATIONS

2000	Baggett K., Grande K, Hsu S: Tender Nodules on the Legs of a Cardiac Transplant Recipient. Archives of Dermatology. 136: 791-796, 2000.
2007	Glickman S., Baggett K., Krubert C., Peterson E., Shulman K.: Promoting Quality: The Health-Care Organization from a Management Perspective. International Journal for Quality in Health Care. 19(6):341-348, 2007.
2009	Perlin, J., Baggett, K. Government, Health and System Transformation. In W.B. Rouse and D.A. Cortese (Eds.) Engineering the System of Healthcare Delivery (pp.415-434). IOS Press.

RESEARCH SUPPORT

Secondary Prevention of Cardiovascular Disease – A Resident Physician Barrier Survey
Principal Investigator: Haya R. Rubin, M.D., PhD.
Research Supported by the Robert Wood Johnson Foundation, Robert Wood Johnson Clinical Scholars Program Grant #047945
Role: Co-Investigator

National Institutes of Health, National Center on Minority Health Disparities, Health Disparities Scholar, (Grant # L32-MD 000442), June 2003- June 2005.

EXHIBIT 28 – CURRICULUM VITAE: YNHHS

GAYLE L. CAPOZZALO, FACHE

ADDRESS

Office: Yale New Haven Health
789 Howard Avenue
New Haven, CT 06519
(203) 688-2605

[redacted]

HEALTH SERVICES EXPERIENCE

1997-Present **Executive Vice President / Chief Strategy Officer. Yale New Haven Health System (YNHHS)**, New Haven, Connecticut. Major regional multi-hospital system in Connecticut with assets and annual revenues in excess of $3.4 billion. Report to YNHHS President/CEO; a member of the System senior leadership team consisting of: The President/CEO of YNHHS/YNHH, Chief Operating Officer of Yale-New Haven Hospital the CEOs of Greenwich Hospital and Bridgeport Hospital and Chief Financial Officer of YNHHS. Responsible for leading and directing the growth, diversification, clinical and operational integration, strategy, innovation, markenting, communication, government relations, business development performance management and annual performance measurement process for the System.

Direct shared and corporate services, facilities, real estate and plant engineering, supply chain, leadership development, training and education, corporate compliance and privacy, strategy, government relations, emergency preparedness, grant development, marketing, communication and business development.

Member of the following YNHHS Boards of Directors:

- Greenwich Hospital and related corporations, Greenwich, CT
- Bridgeport Hospital and related corporations, Bridgeport, CT
- Ambulatory Services Corporation – provides radiology, surgery and recovery services in southern CT
- Shoreline Surgical Corporation – a joint venture with physicians (chair)
- Physician practice foundation for physician employment (chair)
- Continuing Services -- long term care and rehabilitation

Accomplishments:

- Led team to purchase assets of 500 bed academic medical center
- Established, developed and led non-profit physician foundation to employ physicians across the System
- Created clinical integrated physician network
- Created System to System strategic alliances
- Led the transition of a $40 million Ambulatory Services Corporation through turnaround and restructuring.
- Expanded System by adding hospitals, ambulatory centers and physician practices
- Created and directed the development of statewide service lines in Oncology, Cardiology and Pediatrics
- Facilitated the establishment and strategic direction of Yale-New Haven Hospital service lines in eight specialties
- Led the development of a full-service 80,000 square foot ambulatory care center, including ambulatory surgery, radiation therapy, satellite emergency services, laboratory services, physician offices and radiology services.

- Instrumental in the design and implementation of a Systemwide performance management strategy and structure to enhance clinical quality, patient safety and operations performance. The strategy included the development of a performance management infrastructure, full-time performance management coordinators, an electronic balanced scorecard to provide managers with timely, detailed information to monitor, communicate and improve performance and an Institute for Excellence to develop leadership for the future. Responsible for directing and managing the effort.
- Created and direct the Institute for Excellence, Systemwide management development, succession planning and corporate leadership, training and education function.
- Led the integration and standardization of clinical service lines (heart, cancer, pediatrics, neurosciences) and administrative services across the System.
- Led the development of a Systemwide three-year standardization project that standardized 365 operational and administrative processes across the System.
- Created and manage Systemwide Office of Emergency Preparedness, Systemwide corporate compliance, Systemwide compensation and benefit management, and Systemwide strategic planning process to enhance collaboration, improve performance and create economies of scale.

1993 – 1997 **Senior Vice President. Organizational Development. Sisters of Charity of the Incarnate Word Health Care System (SCH),** Houston, Texas. Major Catholic multi-hospital system (14th largest health care system - $2 billion in assets) (3932 acute beds, 620 long-term care and residential beds and numerous health businesses and programs). Report to System President/CEO; a member of the senior leadership team of the System; interact regularly with System governance and member of Board Committees. Responsible for leading and directing Systemwide Leadership Development, System Organizational Development, Growth and Diversification of the Ministry, System Managed Care, System Human Resources, System Continuous Quality Improvement and Quality Assurance, System Strategic Planning and System Communications functions including staffs. Responsible for leading the System efforts in the development and operation of integrated community health networks (ICHN) and mergers and acquisitions.

Accomplishments:

- Instrumental in the design and implementation of a regionalization strategy for (SCH), health care centers and services in Southeast Texas.
- Instrumental in the design and implementation of a regionalization strategy for (SCH), health care centers and services in the state of Louisiana.
- Led the transition of the Sisters of Charity of the Incarnate Word to co-sponsorship of Catholic Healthcare West, including the transition of two (SCH), health care centers to CHW.
- Led the development, implementation and governance of a statewide joint venture triple option insurance product in Louisiana with Ochsner Clinic. The HMO grew from 70,000 to 130,000 lives in one year.
- Instrumental in the development, implementation and governance of a $100 million joint venture health network in Houston, Texas between (SCH), and Memorial Health System, the largest not for profit health care system in Houston. The $100 million health network includes physician practices, group practices, management services organization, clinics, home health, wellness services, and a PPO, TPA, HMO and indemnity insurance product
- Led the development, implementation and management of numerous physician

hospital organizations (PHO) in Louisiana and Texas.

- Led the development, implementation, governance and management of a Louisiana statewide MSO, employing 75 physicians and managing 35 physician practices.
- Led the development, implementation, governance and management of a risk insurance joint venture with Arkansas Blue Cross/Blue Shield.
- Directed a 25,000 enrollee Department of Defense HMO until its integration into the Memorial SCH Health Network.
- Member of governing board of two HMOs, PPOs and insurance companies. Member of governing board and officer of a 75-physician management services organization (MSO).
- Instrumental in the development and implementation of the reengineering of (SCH), corporate office resulting in a reduction of hierarchy, initiation of process work teams, reduction of costs and focus on strategic leadership and creating the System's future.
- Initiated and administered Systemwide leadership development program including education, succession planning, competency based behavior performance evaluations, etc.
- Led the development and administration of a systemwide initiative to fast track qualified women to senior leadership.
- Instrumental in the reduction of costs per weighted discharge by 25% in a three-year period.

1982 - 1993 **Strategic Development. SSM Health Care System.** St. Louis, Missouri. Major Catholic multi-hospital system (4,000 acute beds, 500 long term care and residential beds and numerous health businesses and programs).

1986 – 1993 **Senior Vice President** Reported to System President/CEO; a member of the senior leadership of the System; interacted regularly with System governance; directed Corporate Strategic Planning, Corporate Communications, Corporate Managed Care, Physician/Hospital Organization Directors and staffs. Member of Board of Directors for all System for profit corporations. Responsibilities included organizing and directing the System strategic planning process; developing strategic planning policies and marketing strategies for the System; directing research and development function of the System; directing managed care activities of the System; directing networking activities of the System, e.g., collaboration, acquisition and affiliation; directing communication function of the System including advertising and public relations. Instrumental in implementing Clinical Quality Improvement. Responsible for leading System cross functional teams in implementing a new System-wide strategic and financial planning process which incorporates Continuous Quality Improvement principles, implementing patient-focused care, developing integrated delivery networks in specific geographical areas and establishing System-wide customer feedback mechanisms for physicians. Responsible for managing and/or consulting in Continuous Quality Improvement, strategic planning, marketing, delivery system integration and managed care at twenty-four member institutions and programs. Responsibilities also included developing Continuous Quality Improvement implementation plans, curriculum and teaching Continuous Quality Improvement courses throughout the System. Lead the system efforts to regionalize all health care centers and services in the greater St. Louis area

1982 - 1986 **Corporate Director of Planning/Marketing**. Reported to President of the Governing Board of the System. Supervised corporate planning, marketing and managed care

staffs. Responsibilities included organizing and directing the first system planning process and development of a new structure for the system. Responsibilities also included directing the marketing research, product development, marketing strategy development and alternative delivery activity of the system.

1981 – 1982 **Principal, Health Studies Institute. Inc.,** Columbia, Missouri. Consultant and Project Director for planning, management and education to health care organizations.

1980 - 1981 **Business Development Staff. St. Louis University Hospital and Clinics,** St. Louis, Missouri. Major responsibility included the development of an education subsidiary corporation. Reported to the Chief Operating Officer of the hospital.

1978 - 1980 **Faculty Member. University of Missouri-Columbia. Graduate Studies in Health Services Management.** Major responsibilities included developing and coordinating a baccalaureate degree program in Health Services Management; developing and teaching courses in health care delivery, management and planning. Other responsibilities included student advisement and curriculum design.

EDUCATION

Post Masters Post-Master studies: St. Louis University, Center for Health Services Education and Research, St. Louis, Missouri, specialized in Health Services Marketing and Administration. Doctoral comprehensive examinations completed.

MSPH Master of Science in Public Health (MSPH) with a concentration in Health Planning; University of Missouri-Columbia, Department of Health Services Management.

BA Bachelor of Arts; University of Maryland, College Park, Maryland.

APPOINTMENTS

Professional

- Immediate Past Chairman, American College of Healthcare Executives (ACHE) (2013-2014)
- Chairman, American College of Healthcare Executives (ACHE) (2012-2013)
- Member, Institute for Healthcare Improvement, Audit and Compliance Committee (2012 - 2013)
- Board Member, VHA New England (2001-Present); Chair (2010 – 2013)
- Board Member, Secretary, Past Chair, Connecticut Association of Healthcare Executives (2004-Present)
- Board Member, Greenwich Health Care Services. (1997-Present)
- Board Member, Bridgeport Hospital & Healthcare Services. (1997–Present)
- Alumni Board, University of Missouri-Columbia (2003–Present)
- American College of Healthcare Executives (ACHE) Regents Advisory Council– CT. (1999-Present)
- Co-Chair, The Leadership Institute (2008–2010)Board Member, Board of Governors, American College to Healthcare Executives (2007-2010)
- Board Member, Board of Overseers, Malcolm Baldrige National Quality Award (2006– 2009)
- Regent, American College of Healthcare Executives (Connecticut) (2004–2007)
- Program Committee, European Forum on Quality Improvement in Health Care. (1995-1999)
- Member, Review Board, Quality Management in Health Care Magazine. (1993-2006)
- Board Member, Institute for Healthcare Improvement. (1993-2001)
- Co-Chair, National Forum on Quality Improvement in Healthcare, sponsored by the Institute for Healthcare Improvement. (1992,1993,1994)
- Vice Chairperson, Executive Committee, Healthcare Quality Management Network, Institute for

Healthcare Improvement. (1991-1994)
- Member, Holy Cross Health System, Board of Directors, Mission & Planning Committee (1990-1994)
- President, Catholic Health System Planners and Marketers. (1988-1989)
- Member, Strategic Planning Committee, Society of Healthcare Planning and Marketing (AMA) (1988-1989)
- Co-Chairperson, Membership Committee, Society of Healthcare Planning and Marketing (19851987)
- Chairperson, St. Louis Association of Women in Health Administration. (1984-1986)
- Vice Chairperson, ACHE Ad Hoc Committee of Women in Health Administration. (1982-1984)

Community
- Board Member, Planned Parenthood of Connecticut (2013-Present)
- Member, Project Advisory Group, Women in Healthcare Leadership, National Center for Healthcare Leadership (2013-Present)
- Board Member/Chair, Connecticut Public Broadcasting. (1999-Present)
- Board Member, International Festival of Arts & Ideas. (2008-2010)
- Board Member/Secretary, New Haven Symphony Orchestra. (1999-2007)
- Member, Executive Committee, National Migrant Worker Council, Inc. (1993-1995)
- Board Member, National Migrant Worker Council, Inc. (1992-1995)

Education Faculty
- Faculty Member, Yale University, Department of Epidemiology and Public Health. (2000-Present)
- Preceptor, University of Missouri-Columbia, Health Services Management (June 2003 – Present)
- Faculty Member, Institute for Healthcare Improvement, Boston, MA. (1992-Present)
- Adjunct Faculty Member, St. Louis University, Center for Health Services Education and Research, St. Louis, MO. (1985-Present)

PROFESSIONAL MEMBERSHIPS
- Fellow, American College of Healthcare Executives (ACHE)
- Member, Society of Healthcare Planning and Marketing (AHA).
- Member, American College of Health Care Marketing.

PRESENTATIONS AND PUBLICATIONS (since 2000)

2014 Capozzalo, Gayle. "Quality, Cost and Accountable Care: Models for the Journey." Healthcare Executive. May/June 2014

Presentation, American College of Healthcare Executives
ACQUISITION & INTEGRATION: LEARNING FROM ONE HOSPITAL'S SUCCESSFUL RESULTS EXPERIENCE

Publication: Contributor to The Transformation Takes Shape: Leadership in the healthcare industry during the next three years: Insights from the Oliver Wyman Healthcare CEO Survey 2014

2013 Presentation, American College of Healthcare Executives
LEADERSHIP FOR THE FUTURE

2012 Capozzalo, Gayle. "Successfully Leading Change: Innovation in Service Delivery." International Hospital Federation. Volume 28, Number 4.

Capozzalo, Gayle. "Challenging Assumptions."

Modern Healthcare Magazine March 2012

Presentation, American College of Healthcare Executives
SUCCESSFULLY LEADING CHANGE
Panel, Modern Healthcare Women Leaders in Healthcare
LEADERSHIP IN TIMES OF CHANGE

2011

Presentation, American College of Healthcare Executives
ETHICS: A KEY DRIVER FOR TODAY'S HEALTHCARE ORGANIZATIONS
Presentations, American College of Healthcare Executives
SUCCESSFULLY LEADING CHANGE

Presentation, Long Island University, Westchester Campus
THE HEALTHCARE REFORM FALL-OUT: STRATEGIC CHOICES FOR HEALTHCARE LEADERS
Presentation, American College of Healthcare Executives
FORCES OF CHANGE: NEW LEADERSHIP TO IMPROVE HEALTHCARE IN AMERICA

2010

Presentation, Institute for Healthcare Improvement
ACHIEVING COMPREHENSIVE, SAFE PATIENT FLOW IN AN ACADEMIC MEDICAL CENTER
Presentation, Columbia University
MANAGEMENT CHALLENGES IN THE EVOLVING HEALTHCARE AND INSURANCE SYSTEM
Presentation, the Leadership Institute
YALE NEW HAVEN HEALTH AND EMERGING SOCIAL MEDIA
Presentation, American College of Healthcare Executives
ACHE, NEW JERSEY REGENT BREAKFAST
Presentation, American College of Healthcare Executives Rhode Island Chapter
THE CASE FOR ACHE IN 2010 AND BEYOND

2009

Presentation, the Leadership Institute
PERFORMANCE EXCELLENCE
Presentation, Yale School of Public Health
YALE HEALTHCARE MANAGEMENT PROGRAM
Presentation, Yale University School of Public Health, Class of '54 Reunion
HEALTHCARE REFORM

2008

Presentation, American College of Healthcare Executives
ACHE REFLECTIONS ON LEADERSHIP

2006

Presentation, Institute for Healthcare Improvement
USING MEASUREMENT TO GUIDE IMPROVEMENT

2005

Presentation, Institute for Healthcare Improvement
USING MEASUREMENT TO GUIDE IMPROVEMENT
Presentation, the Leadership Institute
HOSPITALS NOT FOR PROFIT STATUS

Presentation, University of Columbia-Missouri Alumni Meeting
HEALTHCARE IN THE 2000s
Presentation, the Leadership Institute
YALE NEW HAVEN HEALTH HEART INSTITUTE

2004

Presentation, SG2
TECHNOLOGY EVALUATION AND ADOPTION PLANNING
Presentation, Better Management LIVE Worldwide
ACHIEVING PERFORMANCE EXCELLENCE IN A COMPLEX HEALTHCARE DELIVERY SYSTEM
Presentation, the Leadership Institute
STRATEGY ORGANIZATION AND STAFFING: LEADERSHIP INSTITUTE STRATEGISTS' FORUM
Presentation, Institute for Healthcare Improvement National Forum on Quality Management
A PERFORMANCE MANAGEMENT INITIATIVE: YALE NEW HAVEN HEALTH SYSTEM'S STRATEGY

2003

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
STAYING AHEAD OF EMERGING SCIENCE AND TECHNOLOGY

2002

Presentation, National Committee for Quality Healthcare
USING TECHNOLOGY TO DELIVER QUALITY HEALTHCARE
Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
MEDICAL SCIENCE AND TECHNOLOGY: OPPORTUNITY OR THREAT

2001

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
WOMEN EXECUTIVES AND THE GLASS CEILING
Presentation, the Leadership Institute
LEVERAGING CLINICAL DEVELOPMENT TO CREATE AN ENTREPRENEURIAL ENVIRONMENT
Presentation, Modern Healthcare 2001 Healthcare IT Outsourcing Summit
LEVERAGING THE INTERNET TO ENHANCE CUSTOMER RELATIONSHIPS
Presentation, American College of Healthcare Executives
2020 VISION: USING SCIENCE AS THE BASIS FOR HEALTH SYSTEM STRATEGY

2000

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
WOMEN IN LEADERSHIP IN THE NEXT CENTURY
Presentation, VHA Northeast
TRENDS IN HEALTH SYSTEM DEVELOPMENT

CURRICULUM VITAE



RICHARD D'AQUILA
[redacted]

[redacted]

BUSINESS ADDRESS:

Yale-New Haven Hospital
20 York Street
New Haven, CT 06510
Telephone: (203)-688-2606

PROFESSIONAL EXPERIENCE:

June, 2014
President

President
Yale-New Haven Hospital
Executive Vice President
Yale-New Haven Health System

February, 2012
June, 2014

President and Chief Operating Officer
Yale-New Haven Hospital
Executive Vice President
Yale New Haven Health System

May, 2006 to
February, 2012

Executive Vice President and Chief Operating Officer
Yale-New Haven Hospital/Yale New Haven Health System

Organizational Profile

Yale New Haven Health System (YNHHS) is a 1597-bed delivery network formed in 1995 which consists of Yale-New Haven, Bridgeport and Greenwich Hospitals. YNHHS has revenues in excess of $2.3 billion in FY '11 based on 90,000 discharges and 1.3 million outpatient visits. Yale-New Haven Hospital is a 1,008-bed tertiary referral medical center that includes the 201-bed Yale New Haven Children's Hospital and the 76-bed Yale New Haven Psychiatric Hospital. Both Yale New Haven Health System and Yale-New Haven Hospital are formally affiliated with Yale University School of Medicine.

Responsibilities

Overall responsibility for all aspects of day to day operations for Yale-New Haven Hospital (YNHH) and the senior network leader at the Yale New Haven Health System

representing the YNHH delivery network. Hospital leadership responsibilities include direct accountability for the senior leadership team, strategic planning, organizational performance, quality improvement, labor relations and human resources management, system integrations, external relations and service line development. Senior leadership and implementation responsibility for all aspects of the hospital's annual business (operating) plan. Senior level oversight of the hospital's facility plan including construction of a 112-bed, $450 million Comprehensive Cancer Pavilion commencing construction in the fall of 2006.

August, 2000 to April, 2006

Senior Vice President/Chief Operating Officer
New York Presbyterian Hospital/
Weill Cornell Medical Center
New York, New York

Organizational Profile
New York Presbyterian Hospital is a 2,369 bed Academic Medical Center created from the merger between the New York Hospital and the Presbyterian Hospital in the City of New York. The Weill Cornell Medical Center consists of an 880 bed acute care facility in Manhattan and the 239 bed Westchester Division campus in White Plains specializing in behavioral health.

Responsibilities
Overall responsibility for all aspects of day to day operations for the Weill Cornell Medical Center and the Westchester Division, a two campus Academic Medical Center of 1120 beds. Direct responsibility for a total operating expense budget in excess of $450,000,000 and revenues of $850,000,000. Senior leadership and implementation for all aspects of the Medical Center's operating plan including quaternary and tertiary service development, medical staff relations and recruitment, employee relations and labor strategy. System level member of the Corporate Management Team with involvement in strategic and facilities planning, service line development, information technology and performance improvement.

May 1992 to June 2000

Executive Vice President/Chief Operating Officer
St. Vincent's Medical Center
Bridgeport, Connecticut

President
Vincentures, Inc.

President

St. Vincent's Development Corporation, Inc.

Chief Operating Officer of 391 bed, university-affiliated acute care hospital and health system. President/CEO of affiliated subsidiaries with management responsibility at the Medical Center and corporate level. Medical Center responsibilities including day to day operations oversight for patient care services; support services and facilities planning and development. Corporate responsibilities including information systems, ambulatory network development, managed care contracting network oversight and real estate/satellite facility development.

January 1987-April 1992 — **President/CEO**
Health Initiatives Corporation
Providence, Rhode Island

Chief Executive Officer of a consulting practice specializing in strategic planning, business development and project implementation assistance for acute care and specialty hospitals, state planning agencies and private investors. Specific responsibilities included:

- Practice Leadership
- Engagement Planning and Management
- Project Supervision and Control
- Client Interface
- Practice Marketing and Business Development

June 1984-December 1986 — **Vice President**
The Mount Sinai Hospital Corporation
Hartford, Connecticut

June 1981-June 1984 — **Vice President, Division of Planning and Community Services**
The Mount Sinai Hospital
Hartford, Connecticut

June 1979-June 1981 — **Assistant Executive Director**
The Mount Sinai Hospital
Hartford, Connecticut

January 1979-May 1979 — **Administrative Resident**
The Mount Sinai Hospital
Hartford, Connecticut

OTHER APPOINTMENTS:

November 2000 — **Member, Board of Directors**

To Present	Voluntary Hospitals of America/Metro New York New Rochelle, New York
January 1995- June 2000	**Member, Board of Directors** Goodwill Industries Bridgeport, Connecticut
December 1993- June 2000	**Founding Board Member** Park City Primary Care Center Bridgeport, Connecticut
May, 1992- June 2000	**Member, Board of Directors** St. Vincent's Development Corporation Vincentures, Inc. Omicron, Inc. Connecticut Health Enterprises Bridgeport, Connecticut
January 1992- December 1994	**Member, Board of Directors** Visiting Nurses Association of Fairfield County Bridgeport, Connecticut
January 1989- December 1991	**Member, Board of Directors** Easter Seal Society/Meeting Street Rehabilitation Center, Inc. of Rhode Island Providence, Rhode Island
January 1980- December 1989	**Member, Board of Directors** Combined Hospitals Alcohol Program Hartford, Connecticut
September 1985- December 1986	**President, Board of Directors** Regional Alcohol and Drug Abuse Resources, Inc. Hartford, Connecticut
September 1981- December 1986	**Adjunct Faculty/Lecturer** University of Hartford, Barney School of Business and Public Administration West Hartford, Connecticut
January 2001 - Present	**Adjunct Faculty/Residency Preceptor and Lecturer** Robert F. Wagner Graduate School of Public Service New York University New York, N.Y.
December 2000 - Present	**Adjunct Faculty/Lecturer** Weill Medical College of Cornell University Department of Public Health, New York New York, N.Y.
January, 2009 to Present	**Member, Board of Directors** Habitat of Greater New Haven

New Haven, Connecticut

February, 2012 to Present — **Member, Board of Trustees**
Yale-New Haven Hospital
New Haven, Connecticut

September 2012-
May 2013 — **Preceptor**
Fairfield University School of Nursing

EDUCATION:

Yale University School of Medicine
Graduate Program in Hospital Administration
Academic Distinctions: Research Excellence Award (1979)
1979 Graduate

Central Connecticut State University
Bachelor of Arts: Economics/Business
Academic Distinctions: Omicron Delta Epsilon
Economics Honor Society
1977 Graduate

PUBLICATIONS:

1. *Evidence-Based Management in Healthcare*, Kovner, Anthony R., Fine, David J., and D'Aquila, Richard. Health Administration Press Textbook, 2009.

2. *Yale-New Haven Hospital's Asset Acquisition of the Hospital of St. Raphael: Pre-Close, Planning and Transition Activities*, D'Aquila, Richard; Aseltyne, William; Lopman, Abe; Jweinat, Jillian; Ciacco, Teresa; Comerford, Matthew; American Journal of Medicine, August 2013 (Accepted).

3. *Achieving Safe Patient Flow in an Academic Medical Center: A Quality Improvement Journey at Yale-New Haven Hospital;* The Joint Commission Journal on Quality and Patient Safety (Accepted).

PROFESSIONAL AFFILIATIONS:
Fellow, American College of Health Care Executives
Yale Hospital Administration Alumni Association
Connecticut Hospital Association

CHRISTOPHER M. O'CONNOR, FACHE

[redacted]

PROFESSIONAL EXPERIENCE

YALE NEW HAVEN HEALTH SYSTEM, NEW HAVEN, CT
Large academic health system with nearly $3.4 billion in revenue, 2,130 beds and over 19,000 employeess located in southern Connecticut

Executive Vice President, Chief Operating Officer (2012 – present)
Responsible for system operations of this large, academic multihospital integrated delvery system including overseeing the 300+ physician medical foundation.

- Integrated the employee health, occupational medicine and corporate health components into a consolidated and aligned business unit with gains in efficiencies and revenue performance.
- Leading the system's cost and value positioning effort to to improve our annual cost performance by more that $125 million on an ongoing annual basis. Chair of the system implementation steering committee that coordinates the four committees driving this project.
- Coordinating the effort to improve the operations through a system approach in the laboratory, pharmacy, care management, medical staff credentialing – these areas are under system development to meet operational benchmark targets as well as business plan opportunities.
- Leading the "big data" effort across the health system to ensure the capability to manage data and prodnce information meets the changing needs across the health care spectrum.

SAINT RAPHAEL HEALTHCARE SYSTEM, NEW HAVEN, CT
Large community teaching hospital (511 beds) affiliated with the Yale School of Medicine encompassing over $500 million in revenue, long term care and other ancillary services

President and Chief Executive Officer (2009-2012)
Reporting to the Board, oversaw all aspects of the health care system up to and including the asset sale of the system to Yale-New Haven Hospital in September of 2012.

- Led the team to negotiate and ultimately execute a letter of intent and Asset Purchase Agreement with Yale-New Haven Hospital. This process included a full second request investigation by the Federal Trade Commission as well as a reviews by the Attorney General and the Office of Health Care Access regarding a Certificate of Need process.
- Implemented a broad strategy to investigate an opportunity to affiliate with a system that included national catholic systems, for-profit systems and systems within the state of Connecticut.
- Over the two year period managed to maintain operational focus and performance while managing through the purchase process while uncertain of the approval process.
- Improved profitability of the medical center by implementing widespread redesign and cost improvement targets.

CARITAS ST. ELIZABETH'S MEDICAL CENTER, BOSTON, MA
Flagship tertiary teaching hospital of a six-hospital system affiliated with Tufts School of Medicine, located in eastern Massachusetts with 340 licensed beds and 2,500 employees and nearly $400 million in net revenue.

President ***(2006 – 2009)***
Chief Operating Officer ***(2006)***
Responsible for medical center operations including strategic plan, operational performance and community engagement for this urban tertiary teaching hospital.

- Exceeded budgeted performance, earning progressively larger bottom-lines of 1.1%, 1.5% and 2% during the three fiscal years under my leadership.

- Successfully recruited more than 40 new physicians, including key leadership as well as clinical staff to facilitate clinical activity turnaround.
- Improved patient satisfaction from the 70th percentile to the 90th percentile by linking service, quality and access to leadership performance.
- Through a team approach, worked to improve quality goals in many areas including surgical care infection, cardiac outcomes, infection control and ventilator associated pneumonia. Facilitated the implementation of a transparent patient safety program with non-punitive reporting as well as a thorough root cause analysis process to ensure process improvements.
- Recognized as a Tompson Performance Improvement hospital in both 2007 and 2008 in the large teaching category.
- Improved quality outcomes, including benchmark performance in the surgical care infection program to over 95% compliance, and achieved distinction from the Institute of Healthcare Improvement.
- Facilitated programmatic expansion into hyperbaric wound care, neurosciences and robotic surgery. Oversaw milestone construction projects including: a new emergency department, operating suite renovations, a neuroscience and spine center and a multi-disciplinary wound center.
- Led the implementation of Leadership Development initiative across the system in conjunction with the "Achieving Exceptional Care" program – A Studer Group collaborative for over 600 system-wide leaders that focused on improving leadership tools.

OCHSNER HEALTH SYSTEM, NEW ORLEANS, LA

A non-profit, academic, multi-specialty healthcare delivery system dedicated to patient care, research and education. The system includes seven hospitals, more than 35 healthcare centers and 11,000 employees.

Vice President Clinical Operations (2003 – 2006)

Responsible for specialty clinical services including cardiac, oncology, digestive diseases, musculoskeletal, transplant, surgical and perioperative services. Included within these service lines are both clinic operations and hospital services for areas including infusion therapy, radiation therapy, endoscopy, cardiac cath labs and EP labs, 23 OR suites, 6 OR ASC, and 2 plastic surgical OR suites.

- Hurricane Katrina - Led the organization through its response to this national disaster. Ochsner was one of three hospitals to remain functional throughout the storm and flooding. Facilitated the emergency preparedness and response to this regional catastrophe including countless leadership and staff meetings and briefings for the 2,500 staff, patients and dependants sheltered at Ochsner. Assisted in communicating current operational status with media outlets. Assisted in coordination of assets and security needs with state and local emergency operations centers. Maintained a structured decision making process in the face of failing utilities, flooding, civil unrest and numerous operational and human resource issues.
- Assisted in the acquisition process that resulted in the purchase of three Tenet hospitals in the greater New Orleans region. Finalized planning for new cancer center and heart and vascular institute. Facilitated the operational opening of main campus ASC in January 2004.
- Facilitated the focus on patient satisfaction, patient safety and quality, including implementing quality metrics as well as improving patient satisfaction within the operating room setting by 50% over a 12-month period.
- Upon arrival, addressed significant resource shortage within Anesthesia. Implemented recruitment and retention tactics to increase CRNA staff, recruited a new chair and increased staffed anesthesia locations 20% within a year of implementation.
- Improved endoscopy scheduling by both resource allocation and process improvement that increased procedures from 50 to 70 per day.

HOSPITAL OF SAINT RAPHAEL, NEW HAVEN, CT

A 510 bed tertiary teaching hospital affiliated with the Yale School of Medicine in New Haven, Connecticut. St. Raphael's has more than 3,500 employees with a broad range of clinical programs with over $600 million in net patient revenue.

Vice President, Clinical Operations *(2001 – 2003)*
Administrative Director, Departments of Surgery and Emergency Medicine *(1999 – 2001)*
Administrator, St. Raphael Physician Organization *(1997 – 1999)*

Progressive responsibility focused on operational performance of major clinical departments including surgery, emergency medicine, radiology, pathology, gastroenterology, cardiac and oncology services. Responsible for more than 400 FTE's and $200+ million in net patient service revenue.

- Following 9/11, established the first regional emergency response agreement in Connecticut in collaboration with Yale New Haven Hospital and other local healthcare providers.
- Improved OR efficiency by both adding supply (from 19 OR suites to 23) and increasing production by $25 million in gross revenue. Improved cost per case by 5%, and increased OR utilization (saving approximately $3 million in both med/surg supplies and implant costs).
- Implemented OR information system (ORSOS) following a difficult period for both scheduling and preference cards.
- Implemented a capitated defibrillator agreement with Medtronic that enabled savings of more than $1.2 million in pacemaker and defibrillator implants in one year.
- Coordinated the integration of additional subspecialties within the practice, increasing gross professional revenue to $1.5 million.

SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD **(1995 – 1997)**

A large acute tertiary teaching hospital with nearly 500 beds and affiliated with the Johns Hopkins School of Medicine. It is the flagship for Lifebridge Health an two-hospital integrated healthcare delivery system.

Coordinator, Emergency Medicine Operations ***(1996 – 1997)***
Administrative Resident ***(1995 – 1996)***

Following post graduate residency, worked with then CEO Warren Green and the senior leadership team. Remained and managed this large emergency department, which at the time was seeing 65,000 patients annually with more than 20 physicians and PA FTE's.

AFFILIATIONS / BOARD MEMBERSHIPS / RECOGNITIONS

CONNECTICUT HOSPITAL ASSOCIATION, **Board Member** (2010-present)
Diversified Network Services, Board Member (2010-present)
Financial Oversight Committee, Member (2010-present)

VHA, NORTHEAST PURCHASING COALITION, **Board Member** (2012-present)

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES, **Fellow**
Member of Article of the Year Committee

AMERICAN HEART ASSOCIATION, Founders Affiliate, **Board Member** (2008)
Chair of the Heart Walk Leadership Committee

SAINT RAPHAEL LEADERSHIP AWARD, (September, 2012)

GOOD SCOUTING LEADERSHIP AWARD (October, 2012)

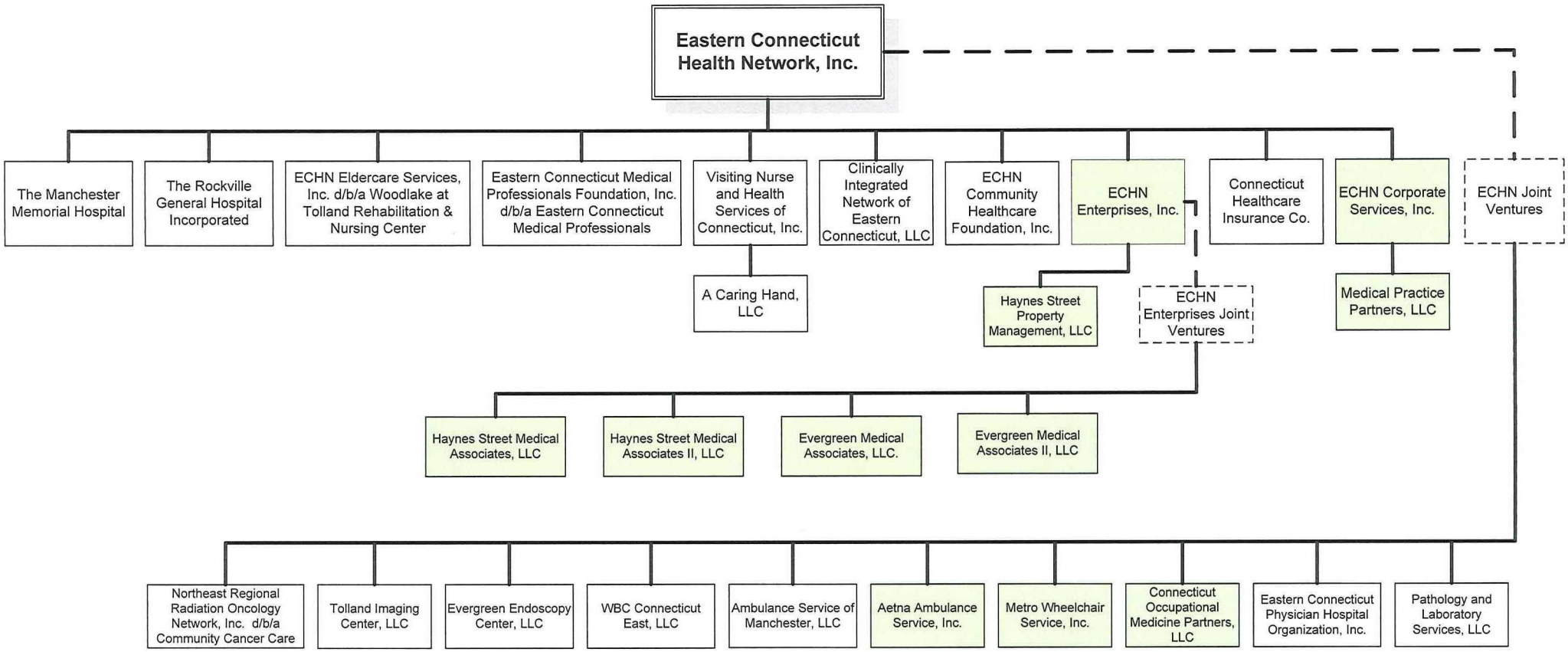
NEW HAVEN BUSINESS TIMES, **Forty under 40 Award** (September 2000)

EDUCATION

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC - 1996
Masters in Health Service Administration

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC - 1993
Bachelor of Arts, Economics

EXHIBIT 29 – ECHN'S ORGANIZATION CHART PRIOR TO ASSET PURCHASE



For Profit Entity

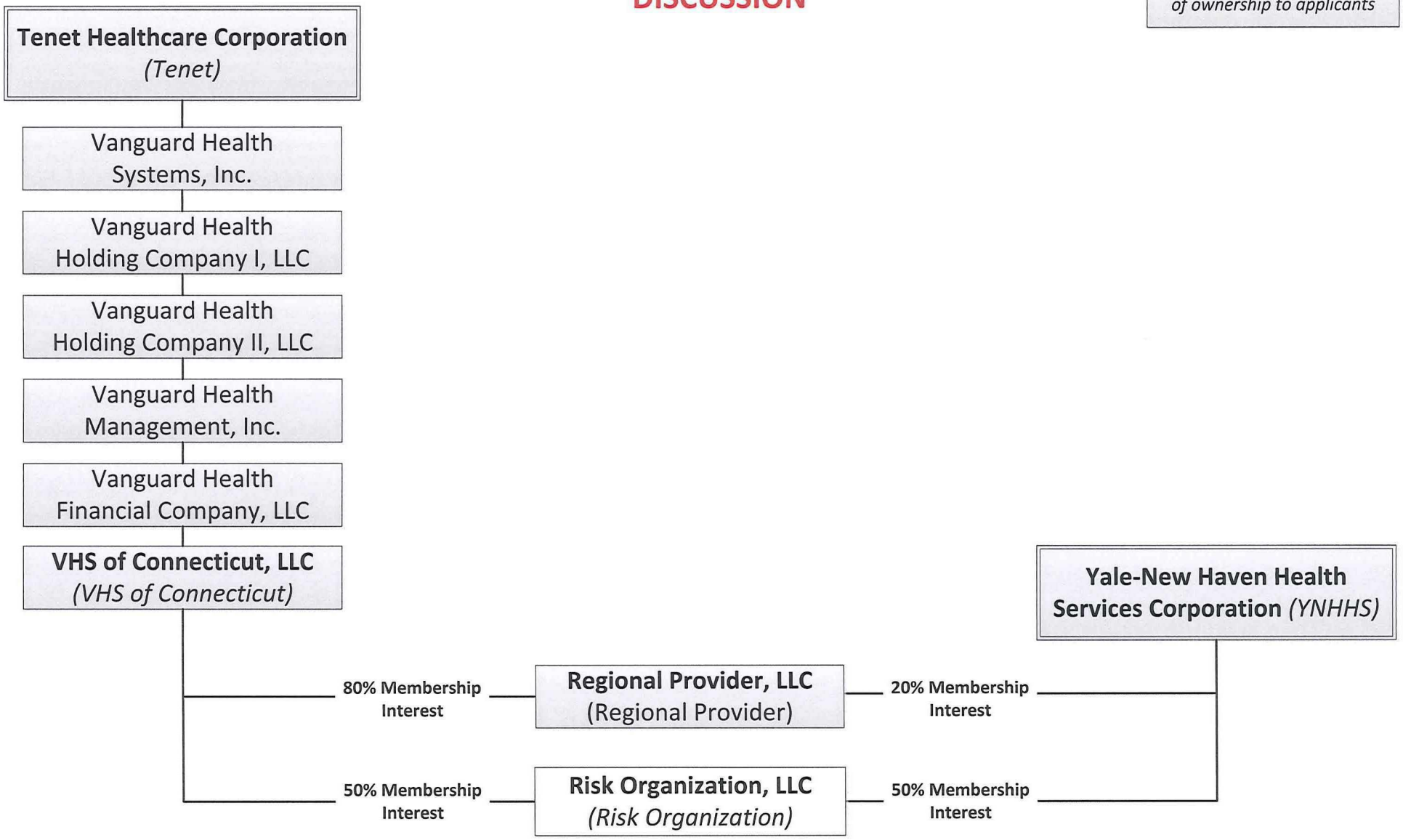
Updated March 2014

EXHIBIT 30 – POST ASSET PURCHASE ORGANIZATIONAL CHART

Post Asset Purchase Organizational Chart: VHS Eastern Connecticut Corporate Parent **Regional Provider LLC** Ownership

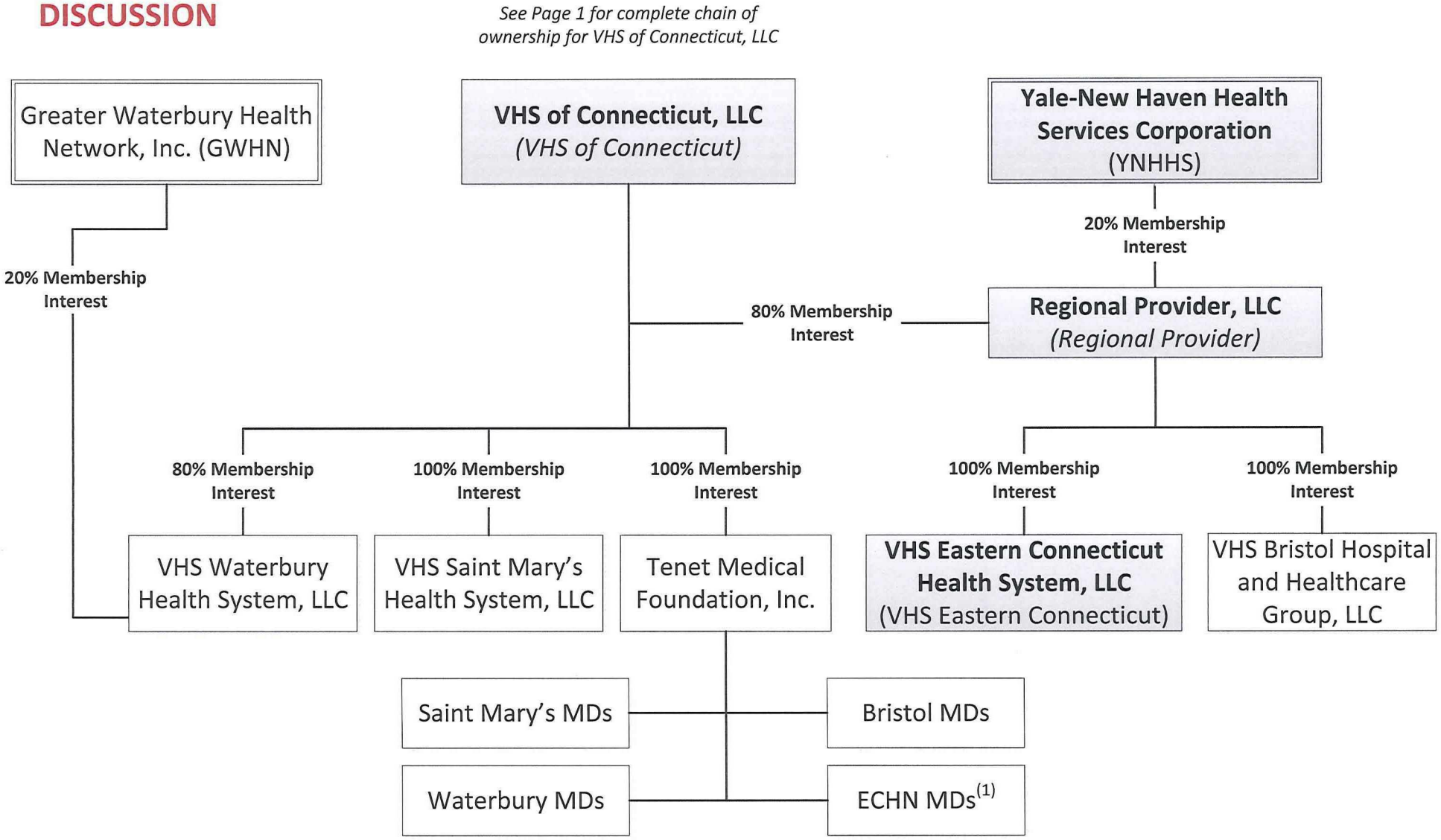
DRAFT FOR DISCUSSION

VHS Eastern Connecticut chain of ownership to applicants



Post Asset Purchase Organizational Chart: Relationship of **VHS Eastern Connecticut** to Parent and Other Parent Subsidiaries

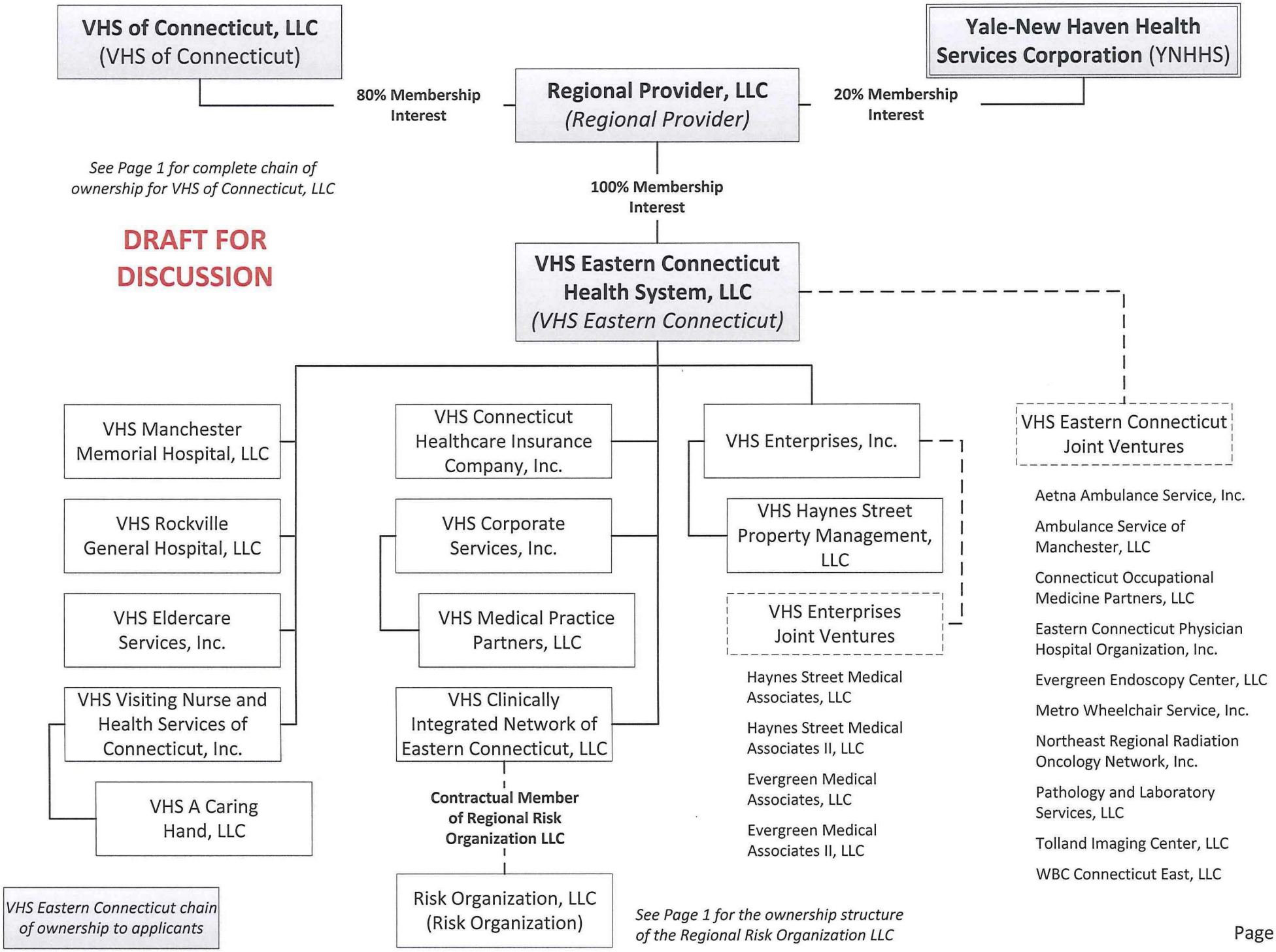
DRAFT FOR DISCUSSION



VHS Eastern Connecticut chain of ownership to applicants

(1) The Tenet Medical Foundation, Inc. will acquire the assets and assume the liabilities of Eastern Connecticut Medical Professionals Foundation, Inc.

Post Asset Purchase Organizational Chart: VHS Eastern Connecticut and Affiliates



1830

EXHIBIT 31 – FINANCIAL ATTACHMENT 1(A)

Name Entity: VHS Eastern CT
Financial Attachment I (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity	FY 2013 Actual	FY 2014 Projected	FY 2015 Projected	FY 2015 Projected	FY 2015 Projected	FY 2016 Projected	FY 2016 Projected	FY 2016 Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected
	Description	Results	W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE											
1	Total Gross Patient Revenue	$891,126	$926,885	$940,765	$18,964	$959,729	$954,852	$29,014	$983,866	$969,151	$39,460	$1,008,611
2	Less: Allowances	$575,823	$609,883	$630,565	$12,711	$643,276	$642,017	$19,508	$661,526	$651,631	$26,532	$678,163
3	Less: Charity Care	$5,181	$3,599	$3,653	$74	$3,727	$3,708	$113	$3,820	$3,763	$153	$3,916
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$310,122**	**$313,403**	**$306,547**	**$6,180**	**$312,726**	**$309,127**	**$9,393**	**$318,521**	**$313,757**	**$12,775**	**$326,531**
5	Medicare	$116,385	$120,171	$114,587	$2,285	$116,871	$114,293	$3,473	$117,766	$116,004	$4,723	$120,728
6	Medicaid	$48,499	$47,955	$46,031	$934	$46,965	$46,720	$1,420	$48,140	$47,420	$1,931	$49,351
7	CHAMPUS & TriCare	$902	$968	$982	$20	$1,002	$997	$30	$1,028	$1,012	$41	$1,053
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$165,786**	**$169,094**	**$161,600**	**$3,239**	**$164,839**	**$162,010**	**$4,923**	**$166,933**	**$164,436**	**$6,695**	**$171,132**
9	Commercial Insurers	$137,819	$137,147	$137,678	$2,793	$140,472	$139,740	$4,246	$143,986	$141,832	$5,775	$147,607
10	Uninsured	$654	$573	$582	$12	$593	$590	$18	$608	$599	$24	$624
11	Self Pay	$2,284	$2,934	$2,978	$60	$3,038	$3,023	$92	$3,114	$3,068	$125	$3,193
12	Workers Compensation	$3,579	$3,654	$3,709	$75	$3,784	$3,764	$114	$3,879	$3,821	$156	$3,976
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$144,336**	**$144,308**	**$144,946**	**$2,941**	**$147,887**	**$147,117**	**$4,470**	**$151,587**	**$149,320**	**$6,080**	**$155,400**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$310,122**	**$313,402**	**$306,547**	**$6,180**	**$312,726**	**$309,127**	**$9,393**	**$318,521**	**$313,757**	**$12,775**	**$326,531**
14	Provision for Bad Debts	$11,142	$11,365	$11,535	$233	**$11,768**	$11,708	$356	**$12,064**	$11,883	$484	**$12,367**
	Net Patient Service Revenue less provision for bad debts	**$298,980**	**$302,038**	**$295,012**	**$5,947**	**$300,958**	**$297,420**	**$9,037**	**$306,457**	**$301,873**	**$12,291**	**$314,164**
15	Other Operating Revenue	$27,116	$27,695	$26,519	($2,735)	**$23,784**	$25,898	($2,735)	**$23,163**	$26,157	($2,735)	**$23,422**
17	Net Assets Released from Restrictions	$1,871	$972	$505	($505)	**$0**	$510	($510)	**$0**	$515	($515)	**$0**
	TOTAL OPERATING REVENUE	**$327,967**	**$330,705**	**$322,035**	**$2,707**	**$324,742**	**$323,828**	**$5,792**	**$329,620**	**$328,545**	**$9,041**	**$337,586**
B.	OPERATING EXPENSES											
1	Salaries and Wages	$163,729	$165,275	$161,287	$3,251	$164,538	$163,686	$4,974	$168,660	$166,121	$6,764	$172,885
2	Fringe Benefits	$47,592	$46,334	$47,235	($7,148)	$40,087	$47,938	($6,733)	$41,204	$48,651	($6,301)	$42,350
3	Physicians Fees	$3,158	$5,128	$5,231	$0	$5,231	$5,335	$0	$5,335	$5,442	$0	$5,442
4	Supplies and Drugs	$36,357	$37,557	$35,394	($529)	$34,865	$36,455	($159)	$36,296	$37,548	$236	$37,784
5	Depreciation and Amortization	$12,291	$12,143	$12,014	$786	$12,800	$11,877	$1,571	$13,448	$11,472	$2,357	$13,829
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,908	$3,801	$3,877	($3,877)	$0	$3,955	($3,955)	$0	$4,034	($4,034)	$0
8	Malpractice Insurance Cost	$8,373	$5,621	$5,733	$0	$5,733	$5,848	$0	$5,848	$5,965	$0	$5,965
9	Lease Expense	$6,265	$6,607	$6,739	$0	$6,739	$6,874	$0	$6,874	$7,011	$0	$7,011
10	Other Operating Expenses	$46,182	$48,109	$47,472	$1,911	$49,383	$48,421	$1,865	$50,286	$49,390	$1,817	$51,207
	TOTAL OPERATING EXPENSES	**$327,855**	**$330,575**	**$324,982**	**($5,605)**	**$319,377**	**$330,389**	**($2,437)**	**$327,952**	**$335,633**	**$840**	**$336,473**
	Provision for Income Taxes[c]	$0	$0	$0	$2,000	**$2,000**	$0	$518	**$518**	$0	$293	**$293**
	Earnings Before Interest, Taxes, Depreciation & Amortization (EBITDA)	**$16,311**	**$16,074**	**$12,944**	**$5,221**	**$18,165**	**$9,270**	**$5,846**	**$15,117**	**$8,418**	**$6,524**	**$14,942**
	INCOME/(LOSS) FROM OPERATIONS	**$112**	**$130**	**($2,947)**	**$6,312**	**$3,365**	**($6,561)**	**$7,711**	**$1,150**	**($7,088)**	**$7,908**	**$820**

Name Entity: VHS Eastern CT
Financial Attachment I (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
LINE	Total Entity	FY 2013	FY 2014	FY 2015	FY 2015	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017
		Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	W/out CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
	NON-OPERATING INCOME / REVENUE	($2,139)	($1,858)	($365)	$0	($365)	($372)	$0	($372)	($380)	$0	($380)
	NET INCOME / EXCESS(DEFICIENCY)OF REVENUE OVER EXPENSES	($2,027)	($1,728)	($3,312)	$6,312	$3,000	($6,934)	$7,711	$777	($7,468)	$7,908	$440
C.	Retained Earnings, beginning of year	$87,876	$85,849	$84,121	$0	$84,121	$80,809	$6,312	$87,121	$73,875	$14,024	$87,898
	Retained Earnings, end of year	$85,849	$84,121	$80,809	$6,312	$87,121	$73,875	$14,024	$87,898	$66,407	$21,931	$88,338
	Principal Payments	$7,079	$8,224	$6,860	($6,860)	$0	$6,368	($6,368)	$0	$5,554	($5,554)	$0
D.	PROFITABILITY SUMMARY											
1	Hospital Operating Margin	0.0%	0.0%	-0.9%	233.2%	1.0%	-2.0%	133.1%	0.3%	-2.2%	87.5%	0.2%
2	Hospital Non Operating Margin	-0.7%	-0.6%	-0.1%	0.0%	-0.1%	-0.1%	0.0%	-0.1%	-0.1%	0.0%	-0.1%
3	Hospital Total Margin	-0.6%	-0.5%	-1.0%	233.2%	0.9%	-2.1%	133.1%	0.2%	-2.3%	87.5%	0.1%
E.	FTEs	2,320	2,297	2,242	45	2,287	2,230	68	2,298	2,219	90	2,309
F.	VOLUME STATISTICS[d]											
1	Inpatient Discharges	11,909	11,451	11,394	57	11,451	11,337	114	11,451	11,280	171	11,451
2	Outpatient Visits	460,670	450,992	453,247	2,255	455,502	455,513	4,544	460,057	457,791	6,867	464,658
	TOTAL VOLUME	472,579	462,443	464,641	2,312	466,953	466,850	4,658	471,508	469,071	7,038	476,109

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

EXHIBIT 32 – ASSUMPTIONS UTILIZED IN DEVELOPING

FINANCIAL ATTACHMENT 1

FINANCIAL ASSUMPTIONS

Projected without CON

1. Main drivers that apply to each year:
    a. 0.5% decline in discharges each year;
    b. 0.5% increase in outpatient visits each year;
    c. 0.5% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions.
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 1.5% each year
    g. Bad debt expense remains consistent at 3.8% of net patient service revenues
    h. Increase of 3% in supplies and drugs pricing each year
    i. Inflation 2% each year
    j. Increase of 1% for other operating revenues each year

2. Other Factors/Assumptions/Adjustments for FY 2015
    a. $4.8 million cut in Medicare due to wage index
    b. $2.6 million cut in Medicaid payments
    c. $3.5 million increase in pension expense
    d. $1.0 million increase in defined contribution plan funding
    e. $3.0 million decline in outpatient revenues
    f. $3.5 million reduction in labor costs to offset above reimbursement cuts
    g. $3.4 million reduction in benefits related to restructured plan designs
    h. $3.7 million reduction to supply chain and purchasing efficiencies
    i. Bad debt expense remains consistent at 3.8% of net patient service revenues
    j. Other operating revenues declining due to reductions in meaningful use incentives and realized gains
    k. Non-operating expenses are reduced to exclude non-recurring items
    l. Medicare reimbursement reduced due to one-time adjustment in FY 14
    m. Other one-time FY 14 adjustments eliminated; inventory, settlements, etc.

3. Other Factors/Assumptions/Adjustments for FY 2016
    a. $2.0 million cut in Medicare due to wage index
    b. Other operating revenues declining further due to reductions in meaningful use incentives

Projected with CON

1. Main drivers that apply to each year:
    a. Discharge volume is unchanged in each projected year;
    b. 1.0% increase in outpatient visits each year;
    c. 1.0% increase in adjustment factor each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    d. Average hourly wage increase of 2.0% each year, except FY2015. No growth is projected for the FY2015 to help mitigate the effects of Medicare and Medicaid reimbursement reductions;
    e. Employee productivity is expected to improve by 0.5% each year resulting from the continued shift in utilization from inpatient to outpatient care delivery;
    f. Net patient revenue per adjusted discharge increase of 1.5% each year;
    g. Bad debt expense remains consistent at 3.8% of net patient service revenues;
    h. Increase of 3% in supplies and drugs pricing each year;
    i. Inflation 2% each year; and
    j. Increase of 1% for other operating revenues each year.

2. Adjustments to financials resulting from CON
    a. Incremental volume drives the incremental revenue. Incremental expense associated with incremental volume is coupled with the assumptions below;
    b. Estimated sales and property tax are layered into the projected years;
    c. Supply expense is reduced by $2.6 million related to increased purchasing power from affiliating with Tenet;
    d. Other operating revenue is reduced by $2.7 million related to the absence of investment income and charitable contributions. Note that these sources of revenue would continue to be available to the community foundation established by ECHN;
    e. Other operating expenses are reduced by approximately $2.3 million reductions in purchased services;
    f. Fringe benefits expense is reduced by approximately $4.5 million as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    g. Pension expenses are deducted from Fringe Benefits;
    h. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    i. Interest expense is reduced to $0 as the standalone entity will not be levered; and
    j. Income tax layered into the expense structure assuming a 40% income tax rate.

EXHIBIT 33 – STAFFING ATTACHMENT I & II (2013 & PROJECTED)

44a. Staffing Attachment I - FY 2013 Actual

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio			Average Nursing[2] Hours per Patient Day
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight	
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30	13.13
01-6076 B II	Med/Surg	RGH	1:2.63	1:3.00	1:4.20	1:4.20	1:5.25	1:7.00	8.02
01-6144 B II South	Med/Surg	RGH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	8.02
01-5060 Emergency Department	ED	RGH	1:1.63	1:20	1:1.80	1:30	1:2.84	1:3.25	n/a
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	9.47
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4	
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	14.73
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5	6.37
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00	8.97
80-6220 Second East	Med/Surg	MMH	1:2.85	1:2.85	1:4.60	1:4.60	1:4.60	1:7.67	7.90
80-6225 ICU	ICU	MMH	1:1.60	1:1.60	1:1.80	1:2.00	1:2.00	1:2.30	13.87
80-6230 Special Care Unit	Med/Surg	MMH	1:2.17	1:2.60	1:3.25	1:3.25	1:3.25	1:4.30	8.88
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:4.40	1:7.30	8.32
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	8.32
80-5060 Emergency Department	ED	MMH	1:2.80	1:2.32	1:2.08	1:5.01	1:3.78	1:2.84	n/a

Nursing Staff/RN to Patient Ratios: The staff to patient ratios were calculated by dividing the budgeted average daily census for the unit or department by the number of nursing staff (or RN) full-time equivelants that were budgeted for that unit or department in a given fiscal year.

Average Nursing Hours per Patient Day: Calculated by dividing the total number of actual worked hours on a unit or department by the number of patient days for that unit or department in a given fiscal year.
Note: "Worked hours" includes regular and overtime hours and does not include other non-patient care hours (i.e. training, paid leave, etc.).

Footnotes:

(1) Nursing Staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (NAs) providing direct patient care.

(2) Nursing hours per patient day should include all nursing staff as defined in #1 above.

(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient accuity)

(4) Number of patients per nursing staff depends on patient acuity.

44a. Staffing Attachment I - FY 2014 Actual

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio			Average Nursing[2] Hours per Patient Day
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight	
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30	14.51
01-6076 B II	Med/Surg	RGH	1:2.57	1:3.00	1:4.50	1:4.50	1:4.50	1:6.00	8.13
01-6144 B II South	Med/Surg	RGH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	8.17
01-5060 Emergency Department	ED	RGH	1:1.90	1:1.75	1:1.75	1:2.90	1:2.80	1:3.50	n/a
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	10.44
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4	
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	15.34
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5	6.14
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00	8.96
80-6220 Second East	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30	8.01
80-6225 ICU	ICU	MMH	1:1.60	1:1.60	1:1.80	1:2.00	1:2.00	1:2.30	14.47
80-6230 Special Care Unit	Med/Surg	MMH	1:2.17	1:2.60	1:3.25	1:3.25	1:3.25	1:4.30	9.17
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30	8.33
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	6.04
80-5060 Emergency Department	ED	MMH	1:2.90	1:2.40	1:2.20	1:5.20	1:4.00	1:3.10	n/a

Nursing Staff/RN to Patient Ratios: The staff to patient ratios were calculated by dividing the budgeted average daily census for the unit or department by the number of nursing staff (or RN) full-time equivelants that were budgeted for that unit or department in a given fiscal year.

Average Nursing Hours per Patient Day: Calculated by dividing the total number of actual worked hours on a unit or department by the number of patient days for that unit or department in a given fiscal year.
Note: "Worked hours" includes regular and overtime hours and does not include other non-patient care hours (i.e. training, paid leave, etc.).

Footnotes:
(1) Nursing Staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (NAs) providing direct patient care.
(2) Nursing hours per patient day should include all nursing staff as defined in #1 above.
(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient accuity)
(4) Number of patients per nursing staff depends on patient acuity.

44a. Staffing Attachment I - FY 2015 Budget

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30
01-6076 B II	Med/Surg	RGH	1:2.57	1:3.00	1:4.50	1:4.50	1:4.50	1:6.00
01-6144 B II South	Med/Surg	RGH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
01-5060 Emergency Department	ED	RGH	1:1.90	1:1.75	1:1.75	1:2.90	1:2.80	1:3.50
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00
80-6220 Second East	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-6225 ICU	ICU	MMH	1:1.60	1:1.60	1:1.80	1:2.00	1:2.00	1:2.30
80-6230 Special Care Unit	Med/Surg	MMH	1:2.17	1:2.60	1:3.25	1:3.25	1:3.25	1:4.30
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
80-5060 Emergency Department	ED	MMH	1:2.90	1:2.40	1:2.20	1:5.20	1:4.00	1:3.10

Nursing Staff/RN to Patient Ratios: The staff to patient ratios were calculated by dividing the budgeted average daily census for the unit or department by the number of nursing staff (or RN) full-time equivelants that were budgeted for that unit or department in a given fiscal year.

Footnotes:

(1) Nursing Staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.

(2) Nursing hours per patient day should include all nursing staff as defined in #1 above.

(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient accuity)

(4) Number of patients per nursing staff depends on patient acuity.

44b. Staffing Attachment II

Assumes volume demands, patient acuity, staff experience levels, and technology consistent with FY2015 budgeted projections

Name of Hospital Unit or Department	Service	Hospital	Year 1 with CON Authorization					
			Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30
01-6076 B II	Med/Surg	RGH	1:2.57	1:3.00	1:4.50	1:4.50	1:4.50	1:6.00
01-6144 B II South	Med/Surg	RGH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
01-5060 Emergency Department	ED	RGH	1:1.90	1:1.75	1:1.75	1:2.90	1:2.80	1:3.50
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00
80-6220 Second East	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-6225 ICU	ICU	MMH	1:1.60	1:1.60	1:1.80	1:2.00	1:2.00	1:2.30
80-6230 Special Care Unit	Med/Surg	MMH	1:2.17	1:2.60	1:3.25	1:3.25	1:3.25	1:4.30
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
80-5060 Emergency Department	ED	MMH	1:2.90	1:2.40	1:2.20	1:5.20	1:4.00	1:3.10

Name of Hospital Unit or Department	Service	Hospital	Year 2 with CON Authorization					
			Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30
01-6076 B II	Med/Surg	RGH	1:2.57	1:3.00	1:4.50	1:4.50	1:4.50	1:6.00
01-6144 B II South	Med/Surg	RGH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
01-5060 Emergency Department	ED	RGH	1:1.90	1:1.75	1:1.75	1:2.90	1:2.80	1:3.50
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00
80-6220 Second East	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-6225 ICU	ICU	MMH	1:1.60	1:1.60	1:1.80	1:2.00	1:2.00	1:2.30
80-6230 Special Care Unit	Med/Surg	MMH	1:2.17	1:2.60	1:3.25	1:3.25	1:3.25	1:4.30
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
80-5060 Emergency Department	ED	MMH	1:2.90	1:2.40	1:2.20	1:5.20	1:4.00	1:3.10

Name of Hospital Unit or Department	Service	Hospital	Year 3 with CON Authorization					
			Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.60	1:2.00	1:2.00	1:1.75	1:2.30	1:2.30
01-6076 B II	Med/Surg	RGH	1:2.57	1:3.00	1:4.50	1:4.50	1:4.50	1:6.00
01-6144 B II South	Med/Surg	RGH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
01-5060 Emergency Department	ED	RGH	1:1.90	1:1.75	1:1.75	1:2.90	1:2.80	1:3.50
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.57	1:3.57	1:6.25	1:6.25	1:6.25	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00	1:6.00
80-6220 Second East	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-6225 ICU	ICU	MMH	1:1.60	1:1.60	1:1.80	1:2.00	1:2.00	1:2.30
80-6230 Special Care Unit	Med/Surg	MMH	1:2.17	1:2.60	1:3.25	1:3.25	1:3.25	1:4.30
80-6265 Third North	Med/Surg	MMH	1:2.75	1:2.75	1:4.40	1:4.40	1:5.50	1:7.30
80-9912 Third West	Med/Surg	MMH	1:3.00	1:3.00	1:3.00	1:6.00	1:6.00	1:6.00
80-5060 Emergency Department	ED	MMH	1:2.90	1:2.40	1:2.20	1:5.20	1:4.00	1:3.10

Footnotes:

(1) Nursing Staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (Nas) providing direct patient care.

(2) Nursing hours per patient day should include all nursing staff as defined in #1 above.

(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient accuity)

(4) Number of patients per nursing staff depends on patient acuity.

EXHIBIT 34 – STAFFING ATTACHMENT I & II ANCILLARY

(2013 AND PROJECTED)

46. Average Weekly Hours for Ancillary Care Providers - Rockville General Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Care Manager						
01-6085 - RGH Care Management	95	96	99	99	99	99
Childbirth Educator						
01-6201 - RGH Women's Center for Wellness	4	4	0	0	0	0
Certified Registered Nurse Anesthetist						
01-5165 - RGH OR	65	80	80	80	80	80
Clinician						
01-5216 - RGH Interventional Radiology	36	34	53	53	53	53
CT Technologist						
01-5030 - RGH CT Scans	76	73	64	64	64	64
01-5218 - RGH Evergreen Imaging Center	31	23	21	21	21	21
Dialysis Technician						
Multiple Inpatient Units	6	10	10	10	10	10
Dietitian						
01-6201 - RGH Women's Center for Wellness	0	2	4	4	4	4
Emergency Department Technician						
01-5060 - RGH Emergency Department	201	200	212	212	212	212
Endoscopy Assistant						
01-5065 - RGH Endoscopy	64	63	64	64	64	64
Licensed Practical Nurse						
01-5060 - RGH Emergency Department	4	2	0	0	0	0
01-5063 - Urgent Care (South Windsor)	10	23	18	18	18	18
Manager Rehab Svcs						
01-5200 - RGH Physical Therapy	33	33	32	32	32	32
MRI Technologist						
01-5110 - RGH MRI	68	62	60	60	60	60
01-5218 - RGH Evergreen Imaging Center	18	24	57	57	57	57
MRI/CT Scan Tech Aide						
01-5110 - RGH MRI	31	31	35	35	35	35

46. Average Weekly Hours for Ancillary Care Providers - Rockville General Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Nuclear Medicine Technologist						
01-5125 - RGH Nuclear Medicine	60	71	28	28	28	28
Nurse Practitioner						
01-5077 - RGH Maternity Care Center	20	14	18	18	18	18
01-6201 - RGH Women's Center for Wellness	3	1	0	0	0	0
Occupational Therapist						
01-5150 - RGH Occupational Therapy	16	16	18	18	18	18
01-6121 - RGH Occupational Therapy (Vernon)	12	12	11	11	11	11
Occupational Therapy Assistant						
01-5150 - RGH Occupational Therapy	16	16	21	21	21	21
Operating Room Technician						
01-5165 - RGH OR	157	144	166	166	166	166
Paramedic						
01-5060 - RGH Emergency Department	157	151	145	145	145	145
Patient Care Assistant						
01-5165 - RGH OR	99	114	99	99	99	99
Phlebotomist						
01-5100 - RGH Lab	525	478	407	407	407	407
Physical Therapist						
01-5200 - RGH Physical Therapy	101	109	96	96	96	96
01-5202 - RGH Physical Therapy (Ellington)	56	56	57	57	57	57
01-6118 - RGH Physical Therapy (Vernon)	65	55	64	64	64	64
Physician						
01-5064 - Urgent Care (South Windsor)	57	63	64	64	64	64
01-5165 - RGH OR	162	163	163	163	163	163
01-5216 - RGH Interventional Radiology	48	48	48	48	48	48
30-9908 - Hospitalists	278	336	336	336	336	336
Physician Assistant						
30-9922 - Orthopedic Services	74	75	75	75	75	75
30-9953 - General Surgery Services	68	71	71	71	71	71

46. Average Weekly Hours for Ancillary Care Providers - Rockville General Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Psychiatric Technician						
01-5060 - RGH Emergency Department	9	14	0	0	0	0
Psychiatrist						
01-6168 - RGH OP Behaviroal Health (Child & Adol)	34	32	35	35	35	35
Radiological Technologist						
01-5215 - RGH Diagnostic Radiology	347	377	301	301	301	301
01-5218 - RGH Evergreen Imaging Center	64	78	64	64	64	64
01-6201 - RGH Women's Center for Wellness	150	159	152	152	152	152
Radtech-Special Procedures *(Changed to Interventional Radiology Technologist 9/30/2014)*						
01-5215 - RGH Diagnostic Radiology	36	1	25	25	25	25
01-5216 - RGH Interventional Radiology	45	65	67	67	67	67
Registered Nurse						
01-5010 - RGH Cardiac Rehab	65	59	53	53	53	53
01-5060 - RGH Emergency Department	642	637	584	584	584	584
01-5063 - Urgent Care (South Windsor)	54	42	42	42	42	42
01-5065 - RGH Endoscopy	173	170	149	149	149	149
01-5077 - RGH Maternity Care Center	34	18	21	21	21	21
01-5165 - RGH OR	231	202	216	216	216	216
01-5175 - RGH PACU	116	104	219	219	219	219
01-5245 - RGH Stress Lab	20	18	21	21	21	21
01-6082 - RGH ODS	167	150	142	142	142	142
01-6201 - RGH Women's Center for Wellness	3	3	4	4	4	4
01-6295 - RGH Float Pool	12	2	0	0	0	0
Rehab Aide						
01-5200 - RGH Physical Therapy	44	44	71	71	71	71
Resident/Intern Physician						
01-9135 - Medical Education Faculty	0	22	96	96	96	96
Respiratory Therapist						
01-5015 - RGH Cardio-Pulmonry	238	237	226	226	226	226
Respiratory Therapy Assistant						
01-5015 - RGH Cardio-Pulmonry	33	23	32	32	32	32

46. Average Weekly Hours for Ancillary Care Providers - Rockville General Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Sonographer						
01-5024 - RGH Echocardiogrphy	20	35	32	32	32	32
Speech Pathologist						
01-5220 - RGH Speech & Hearing	18	19	18	18	18	18
Student Nurse						
01-5060 - RGH Emergency Department	2	8	0	0	0	0
Therapist						
01-6168 - RGH OP Behaviroal Health (Child & Adol)	18	21	28	28	28	28
Ultrasonographer						
01-5218 - RGH Evergreen Imaging Center	55	40	42	42	42	42
01-5255 - RGH Ultrasound	99	126	99	99	99	99
01-6201 - RGH Women's Center for Wellness	60	97	99	99	99	99

46. Average Weekly Hours for Ancillary Care Providers - Manchester Memorial Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Advanced Practice Registered Nurse						
30-9928 - Neonatal Services	97	98	111	111	111	111
30-9941 - Gastroenterology Services	67	69	71	71	71	71
80-6174 - MMH Behavioral Health - Adolescent Outpatient Services	33	33	32	32	32	32
Care Manager						
80-5171 - MMH Wound Care Center	56	48	99	99	99	99
80-6485 - MMH Care Management	283	297	280	280	280	280
Certified Registered Nurse Anesthetist						
80-5165 - MMH OR	153	186	186	186	186	186
Clinician						
80-5216 - MMH Interventional Radiology	80	82	81	81	81	81
80-6150 - MMH Behavioral Health - Adult Partial Hospital Program	304	289	287	287	287	287
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	84	94	99	99	99	99
80-6170 - MMH Behavioral Health - Adolescent Inpatient Unit	32	32	32	32	32	32
80-6172 - MMH Behavioral Health - Adult Outpatient Services	226	212	255	255	255	255
Crisis Worker						
30-9944 - Crisis Services	187	194	207	207	207	207
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	33	21	0	0	0	0
CT Technologist						
80-5030 - MMH CT Scan	243	241	237	237	237	237
Diabetes Educator						
80-5035 - MMH Diabetes Self Management	20	18	18	18	18	18
Dialysis Technician						
Multiple Inpatient Units	27	27	27	27	27	27
Emergency Department Physician						
80-5061 - MMH Emergency Department	547	546	541	541	541	541
Emergency Department Technician						
80-5060 - MMH Emergency Department	603	534	495	495	495	495
Endoscopy Assistant						
80-5065 - MMH Endoscopy	156	169	149	149	149	149

46. Average Weekly Hours for Ancillary Care Providers - Manchester Memorial Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Lactation Consultant						
80-5078 - MMH Perinatal Education	35	34	35	35	35	35
Licensed Practical Nurse						
80-5060 - MMH Emergency Department	34	32	60	60	60	60
80-5171 - MMH Wound Care Center	95	83	71	71	71	71
80-6400 - MMH Ambulatory Services Center	18	19	32	32	32	32
Manager Rehab Svcs						
80-7230 - MMH Physical Therapy (Glastonbury)	29	28	28	28	28	28
Mental Health Counselor						
80-6160 - MMH Behavioral Health - Adolescent Partial Hospital Program	64	74	78	78	78	78
MRI Technologist						
80-5110 - MMH MRI	81	89	71	71	71	71
MRI/CT Scan Tech Aide						
80-5110 - MMH MRI	37	26	35	35	35	35
Nuclear Medicine Technologist						
80-5125 - MMH Nuclear Medicine	113	91	50	50	50	50
Nurse Practitioner						
80-6926 - MMH CorpCare	26	26	25	25	25	25
Occupational Health Nurse						
80-6926 - MMH CorpCare	18	14	18	18	18	18
Occupational Therapist						
80-5150 - MMH Occupational Therapy	28	29	28	28	28	28
80-5306 - MMH Occupational Therapy (South Windsor)	32	33	32	32	32	32
80-6160 - MMH Behavioral Health - Adolescent Partial Hospital Program	25	25	0	0	0	0
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	26	26	25	25	25	25
80-6174 - MMH Behavioral Health - Adolescent Outpatient Services	3	4	4	4	4	4
Occupational Therapy Assistant						
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	34	32	32	32	32	32

46. Average Weekly Hours for Ancillary Care Providers - Manchester Memorial Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Operating Room Technician						
80-5165 - MMH OR	451	421	421	421	421	421
Patient Care Assistant						
80-5060 - MMH Emergency Department	36	23	149	149	149	149
80-5165 - MMH OR	265	254	230	230	230	230
80-6400 - MMH Ambulatory Services Center	32	32	11	11	11	11
Phlebotomist						
80-5100 - MMH Lab	593	612	548	548	548	548
80-7140 - MMH Lab - Patient Service Center	329	344	382	382	382	382
Physical Therapist						
80-5200 - MMH Physical Therapy	226	245	195	195	195	195
80-5305 - MMH Physical Therapy (South Windsor)	128	101	99	99	99	99
80-7230 - MMH Physical Therapy (Glastonbury)	29	30	28	28	28	28
Physical Therapy Assistant						
80-5200 - MMH Physical Therapy	29	30	32	32	32	32
80-5305 - MMH Physical Therapy (South Windsor)	56	60	60	60	60	60
80-7230 - MMH Physical Therapy (Glastonbury)	45	45	53	53	53	53
Physician						
30-9908 - Hospitalists	474	580	580	580	580	580
30-9928 - Neonatal Services	92	92	92	92	92	92
30-9976 - Wound Care	11	24	24	24	24	24
80-5061 - MMH Emergency Department	37	37	0	0	0	0
80-5165 - MMH OR	378	379	379	379	379	379
80-5216 - MMH Interventional Radiology	48	48	48	48	48	48
80-6926 - MMH CorpCare	32	31	28	28	28	28
80-9135 - Medical Education Faculty	0	52	74	74	74	74
Physician Assistant						
30-9922 - Orthopedic Services	172	174	174	174	174	174
30-9928 - Neonatal Services	34	35	35	35	35	35
30-9953 - General Surgery Services	157	166	166	166	166	166
80-5061 - MMH Emergency Department	484	450	425	425	425	425
Polysomnographic Technician						
80-5230 - MMH Sleep Lab	218	180	170	170	170	170

46. Average Weekly Hours for Ancillary Care Providers - Manchester Memorial Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Psychiatric Technician						
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	328	369	340	340	340	340
80-6170 - MMH Behavioral Health - Adolescent Inpatient Unit	102	108	92	92	92	92
Psychiatrist						
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	21	17	18	18	18	18
80-6172 - MMH Behavioral Health - Adult Outpatient Services	30	6	18	18	18	18
80-9135 - Medical Education Faculty	0	15	0	0	0	0
Radiological Technologist						
80-5215 - MMH Diagnostic Radiology	398	393	386	386	386	386
80-6926 - MMH CorpCare	40	40	35	35	35	35
80-7060 - MMH Glastonbury Diagnostic Center	41	32	25	25	25	25
Radtech-Special Procedures *(Changed to Interventional Radiology Technologist 9/30/2014)*						
80-5215 - MMH Diagnostic Radiology	17	11	0	0	0	0
80-5216 - MMH Interventional Radiology	36	66	28	28	28	28
Registered Dietician						
80-5035 - MMH Diabetes Self Management	35	47	35	35	35	35
Registered Nurse						
80-5010 - MMH Cardiac Rehab	60	60	57	57	57	57
80-5060 - MMH Emergency Department	1,099	1,082	938	938	938	938
80-5065 - MMH Endoscopy	273	282	262	262	262	262
80-5160 - MMH Ambulatory Medical	172	158	103	103	103	103
80-5165 - MMH OR	565	543	580	580	580	580
80-5171 - MMH Wound Care Center	22	36	0	0	0	0
80-5175 - MMH PACU	283	263	244	244	244	244
80-5245 - MMH Stress Lab	46	48	46	46	46	46
80-6400 - MMH Ambulatory Services Center	323	322	294	294	294	294
Rehab Aide						
80-5200 - MMH Physical Therapy	67	65	71	71	71	71
Resident/Intern Physician						
80-9135 - Medical Education Faculty	145	614	863	863	863	863
Respiratory Therapist						
80-5015 - MMH Cardio-Pulmonry	434	405	382	382	382	382

46. Average Weekly Hours for Ancillary Care Providers - Manchester Memorial Hospital

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours budgeted for FY 2015 (as of 10/20/2014).
(4) Assumes average hours per week will remain at FY 2015 budgeted levels for the first 3 years after the asset purchase.

	Average Hours per Week[1]			Projected Average Hours per Week[4]		
Ancillary Caregiver by Department[2]	FY 2013	FY 2014	FY 2015[3]	Year 1	Year 2	Year 3
Respiratory Therapy Assistant						
80-5015 - MMH Cardio-Pulmonry	37	60	60	60	60	60
Retractor Holder						
80-5165 - MMH OR	76	67	71	71	71	71
School Nurse						
80-6171 - MMH Behavioral Health - Adolescent Education	21	23	32	32	32	32
Social Worker						
80-6171 - MMH Behavioral Health - Adolescent Education	39	31	53	53	53	53
80-6485 - MMH Care Management	15	11	71	71	71	71
Sonographer						
80-5024 - MMH ECHOcardiogrphy	66	69	67	67	67	67
Speech Pathologist						
80-5220 - MMH Speech & Hearing	35	37	32	32	32	32
Student Nurse						
80-5060 - MMH Emergency Department	8	10	0	0	0	0
Surgical Prep Technician						
80-7145 - MMH Lab - Surgical Pathology	34	46	60	60	60	60
Therapist						
80-6160 - MMH Behavioral Health - Adolescent Partial Hospital Program	94	110	145	145	145	145
80-6174 - MMH Behavioral Health - Adolescent Outpatient Services	21	22	42	42	42	42
Ultrasonographer						
80-5255 - MMH Ultrasound	106	157	166	166	166	166
Woman's Health Nurse Navigator						
80-5260 - MMH Breast Center	32	30	32	32	32	32
Wound Care Technician						
80-5171 - MMH Wound Care Center	9	18	14	14	14	14

EXHIBIT 35 – STATEMENTS OF DEFICIENCY – FILED ELECTRONICALLY ONLY

EXHIBIT 36 – LEAPFROG SAFETY SCORES

Tenet Healthcare
LeapFrog Safety Scores
As Reported April 2014

A
California
DESERT REG MED CTR
DOCTORS HOSP OF MANTECA
FOUNTAIN VLY REG HOSP MED CTR
LAKEWOOD REG MED CTR
LOS ALAMITOS MED CTR
SAN RAMON REG MED CTR
SIERRA VISTA REG MED CTR
TWIN CITIES COMM HOSP
Central
DES PERES HOSP
SIERRA PROVIDENCE EAST MED CTR
ST FRANCIS BARTLETT MED CTR
ST FRANCIS HOSP
Florida
CORAL GABLES HOSP
DELRAY MED CTR
North Shore MC FLORIDA MED CTR Campus
NORTH SHORE MED CTR
PALM BEACH GARDENS MED CTR
ST MARY'S MED CTR
WEST BOCA MED CTR
Southern
ATLANTA MED CTR
BROOKWOOD MED CTR
NORTH FULTON REG HOSP
PIEDMONT MED CTR
Detroit
DMC Detroit Receiving Hospital
DMC Harper University Hospital
DMC Huron Valley-Sinai Hospital
DMC Sinai-Grace Hospital
San Antonio
Baptist Medical Center
Mission Trail Baptist Hospital
North Central Baptist Hospital
Northeast Baptist Hospital
St. Luke's Baptist Hospital
Northeast
MacNeal Hospital
Weiss Memorial Hospital
West Suburban Hospital
Saint Vincent Hospital
MetroWest Medical Center - Framingham Union
MetroWest Medical Center - Leonard Morse Hospital
B
California
DOCTORS MED CTR OF MODESTO
PLACENTIA-LINDA HOSP
Central
CENTENNIAL MED CTR
DOCTORS HOSP WHITE ROCK LAKE
HOUSTON NORTHWEST MED CTR

- LAKE POINTE MED CTR
- NACOGDOCHES MED CTR
- PARK PLAZA HOSP
- SAINT LOUIS UNIVERSITY HOSP
- SIERRA MED CTR

Florida
- GOOD SAMARITAN MED CTR
- HIALEAH HOSP
- PALMETTO GEN HOSP

Southern
- CENTRAL CAROLINA HOSP
- FRYE REG MED CTR
- HILTON HEAD REG MED CTR
- SPALDING REG MED CTR

Northeast
- HAHNEMANN UNIV HOSP

Phoenix
- Arrowhead Hospital
- Maryvale Hospital

C

California
- JOHN F KENNEDY MEM HOSP

Central
- CYPRESS FAIRBANKS MED CTR
- PROVIDENCE MEM HOSP

Southern
- COASTAL CAROLINA MED CTR
- EAST COOPER REG MED CTR

South Texas
- Valley Baptist - Brownsville
- Valley Baptist Medical Center - Harlingen

Northeast
- Westlake Hospital

Phoenix
- Paradise Valley Hospital
- Phoenix Baptist Hospital
- West Valley Hospital

N/A

Central
- PLAZA SPECIALTY HOSP

Southern
- SOUTH FULTON MED CTR
- SYLVAN GROVE HOSP

Detroit
- DMC Children's Hospital of Michigan
- DMC Hutzel Women's Hospital
- DMC Rehabilitation Institute of Michigan
- DMC Surgery Hospital

Northeast
- ST CHRISTOPHER'S HOSP FOR CHILDREN

Phoenix
- Arizona Heart Hospital

EXHIBIT 37 – TJC TOP PERFORMERS

Congratulations to the 2012 *Top Performer on Key Quality Measures®* Hospitals

The Joint Commission recognizes the following accredited hospitals that attained excellence in accountability measure performance during calendar year 2012. As a *Top Performer on Key Quality Measures®*, the following hospitals represent the top 33 percent of all Joint Commission-accredited hospitals that reported accountability measure performance data for 2012.

Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Alabama										
Shelby Baptist Medical Center	Alabaster	✓	✓	✓	✓					
Community Hospital of Andalusia, Inc.	Andalusia			✓	✓					
Anniston HMA, LLC	Anniston	✓	✓	✓	✓					
The Health Care Authority for Medical West, An Affiliate of UAB	Bessemer	✓	✓	✓	✓					
Affinity Hospital, LLC	Birmingham	✓	✓	✓	✓					
Brookwood Medical Center	Birmingham	✓	✓	✓	✓					
Hill Crest Behavioral Health Services	Birmingham								✓	
Princeton Baptist Medical Center	Birmingham	✓	✓	✓	✓					
North Alabama Regional Hospital	Decatur								✓	
Flowers Hospital	Dothan	✓	✓	✓	✓					
Hospital and Behavioral Health	Dothan								✓	
QHG of Enterprise, Inc.	Enterprise			✓	✓					
South Baldwin Regional Medical Center	Foley	✓	✓	✓	✓					
DeKalb Regional Medical Center	Fort Payne	✓	✓	✓	✓					
Greenville Hospital Corporation	Greenville			✓	✓					
Lakeland Community Hospital	Haleyville			✓						
Crestwood Medical Center	Huntsville	✓	✓	✓	✓					
Walker Baptist Medical Center	Jasper	✓	✓	✓	✓					
University of South Alabama Medical Center	Mobile	✓	✓	✓	✓					
Baptist Medical Center East	Montgomery	✓	✓	✓	✓					
Jackson Hospital and Clinic, Inc.	Montgomery	✓	✓	✓	✓					
East Alabama Medical Center	Opelika	✓	✓	✓	✓					
Russell County Community Hospital, LLC	Phenix City				✓					
The Health Care Authority for Baptist Health, An Affiliate of UAB	Prattville			✓						
Russellville Hospital	Russellville	✓		✓	✓					
Vaughan Regional Medical Center, LLC	Selma	✓	✓	✓	✓					
Helen Keller Hospital	Sheffield		✓	✓	✓					
Coosa Valley Medical Center	Sylacauga		✓	✓	✓					
Bryce Hospital	Tuscaloosa								✓	
DCH Regional Medical Center	Tuscaloosa	✓	✓	✓	✓					
Mary Starke Harper Geriatric Psychiatry Center	Tuscaloosa								✓	
Taylor Hardin Secure Medical Facility	Tuscaloosa								✓	
Tuscaloosa VA Medical Center	Tuscaloosa								✓	
Alaska										
Alaska Psychiatric Institute	Anchorage								✓	
Alaska Regional Hospital	Anchorage	✓	✓	✓	✓					
PeaceHealth Ketchikan Medical Center	Ketchikan			✓	✓					
Mat-Su Regional Medical Center	Palmer	✓		✓	✓					
Central Peninsula Hospital	Soldotna			✓	✓					
Arizona										
Western Arizona Regional Medical Center	Bullhead City	✓	✓	✓	✓					
Orthopedic and Surgical Specialty Company, LLC	Chandler				✓					
Banner Gateway Medical Center	Gilbert		✓	✓	✓					
Arrowhead Hospital	Glendale	✓	✓	✓	✓					
Banner Desert Medical Center	Mesa	✓	✓	✓		✓				
Carondelet Holy Cross Hospital, Inc.	Nogales				✓					
Banner Estrella Medical Center-Banner Health	Phoenix	✓	✓	✓	✓					
Maryvale Hospital	Phoenix	✓	✓	✓	✓					
Mayo Clinic Hospital	Phoenix	✓	✓	✓	✓					
Paradise Valley Hospital	Phoenix	✓	✓	✓	✓					
UBH of Phoenix, LLC	Phoenix								✓	
Banner Ironwood Medical Center	San Tan Valley			✓	✓					
Banner Boswell Medical Center	Sun City	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immunization
Arkansas										
Baptist Health	Arkadelphia			✓	✓					
Valley Behavioral Health System, LLC	Barling								✓	
Sparks Regional Medical Center	Fort Smith	✓	✓	✓	✓					
Helena Regional Medical Center	Helena		✓	✓						
Arkansas Heart Hospital	Little Rock	✓	✓	✓	✓					
Baptist Health Medical Center-Little Rock	Little Rock	✓	✓	✓						
BHC Pinnacle Pointe Hospital, Inc.	Little Rock								✓	
United Methodist Behavioral Hospital	Maumelle								✓	
Harris Hospital	Newport		✓	✓	✓					
Arkansas Surgical Hospital, LLC	North Little Rock				✓					
Arkansas Methodist Hospital Corporation	Paragould	✓	✓	✓	✓					
Riverview Behavioral Health	Texarkana								✓	
Crittenden Hospital Association	West Memphis		✓	✓						
California										
Kaiser Foundation Hospital-Orange County-Anaheim	Anaheim	✓	✓	✓	✓					
Kaiser Foundation Hospital-Antioch	Antioch	✓	✓	✓	✓					
Sutter Auburn Faith Hospital	Auburn			✓	✓					
Kaiser Foundation Hospitals-Baldwin Park Medical Center	Baldwin Park	✓	✓	✓	✓					
Eden Medical Center	Castro Valley	✓	✓	✓	✓					
Sharp Coronado Hospital	Coronado				✓					
CHCM, Inc.	Costa Mesa								✓	
Aurora Charter Oak-Los Angeles, LLC	Covina								✓	
Kaiser Foundation Hospital-Downey Medical Center	Downey	✓	✓	✓	✓					
Scripps Memorial Hospital-Encinitas	Encinitas	✓	✓	✓	✓					
Encino Hospital Medical Center	Encino			✓						
Fallbrook Hospital Corporation	Fallbrook			✓	✓					
Mercy Hospital of Folsom	Folsom			✓	✓			✓		
Kaiser Foundation Hospital-Fontana	Fontana	✓	✓	✓	✓					
San Joaquin General Hospital	French Camp	✓	✓							
Fresno Heart Hospital, LLC	Fresno	✓			✓					
Kaiser Foundation Hospital-Fresno	Fresno	✓	✓	✓	✓					
Garden Grove Hospital and Medical Center	Garden Grove	✓		✓	✓					
Glendale Adventist Medical Center	Glendale	✓	✓	✓				✓		
Kaiser Foundation Hospital-South Bay	Harbor City	✓	✓	✓	✓					
Kaiser Foundation Hospital-Hayward/ Fremont Medical Center	Hayward	✓	✓	✓	✓					
The Huntington Beach Hospital	Huntington Beach			✓	✓					
Centinela Hospital Medical Center	Inglewood	✓	✓	✓	✓					
Scripps Green Hospital	La Jolla	✓	✓	✓	✓					
Scripps Memorial Hospital-La Jolla	La Jolla	✓	✓	✓	✓					
Grossmont Hospital Corporation	La Mesa	✓	✓	✓	✓					
La Palma Intercommunity Hospital	La Palma	✓		✓	✓					
Lakewood Regional Medical Center	Lakewood	✓	✓	✓	✓					
VA Loma Linda Healthcare System	Loma Linda	✓	✓	✓	✓					
Miller Children's Hospital	Long Beach					✓				
Kaiser Foundation Hospital-Los Angeles Medical Center	Los Angeles	✓	✓	✓	✓					
Ronald Reagan UCLA Medical Center	Los Angeles	✓	✓	✓	✓					
Memorial Hospital Los Banos	Los Banos			✓						
Kaiser Foundation Hospital-Manteca/Modesto	Manteca	✓		✓	✓					
Doctors Medical Center of Modesto	Modesto	✓	✓	✓	✓					
Memorial Medical Center	Modesto	✓	✓	✓	✓					
Kaiser Foundation Hospital-Moreno Valley Community Hospital	Moreno Valley	✓	✓	✓	✓					
Mercy Medical Center Mt. Shasta	Mount Shasta			✓	✓					
El Camino Hospital	Mountain View	✓	✓	✓	✓					
Paradise Valley Hospital	National City	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Kaiser Foundation Hospital-Oakland/Richmond	Oakland	✓	✓	✓	✓					
Sutter East Bay Hospitals-Summit Campus	Oakland	✓	✓	✓	✓					
Children's Hospital of Orange County	Orange					✓				
Lucile Salter Packard Children's Hospital at Stanford	Palo Alto					✓				
Kaiser Foundation Hospitals-Panorama City Medical Center	Panorama City	✓	✓	✓	✓					
Mission Community Hospital	Panorama City		✓	✓	✓					
Aurora Behavioral Health Care/Las Encinas Hospital	Pasadena								✓	
Department of State Hospitals-Patton	Patton								✓	
Placentia-Linda Hospital	Placentia	✓		✓	✓					
Marshall Medical Center	Placerville		✓	✓	✓					
ValleyCare Health System	Pleasanton	✓	✓	✓	✓					
Pomona Valley Hospital Medical Center	Pomona	✓	✓	✓						
Prime Healthcare Services-Shasta, LLC	Redding	✓	✓	✓	✓					
Kaiser Foundation Hospital-Redwood City	Redwood City	✓		✓	✓					
Sequoia Hospital	Redwood City	✓	✓	✓	✓					
Riverside Community Hospital	Riverside	✓	✓	✓	✓					
BHC Alhambra Hospital	Rosemead								✓	
BHC Heritage Oaks Hospital	Sacramento								✓	
Kaiser Foundation Hospital-Sacramento	Sacramento	✓	✓	✓	✓					
Salinas Valley Memorial Hospital	Salinas	✓	✓	✓						
Kaiser Foundation Hospital-San Diego	San Diego	✓	✓	✓	✓					
Scripps Mercy Hospital	San Diego	✓	✓	✓	✓					
Sharp Memorial Hospital	San Diego	✓	✓	✓	✓					
VA San Diego Healthcare System	San Diego	✓	✓	✓	✓					
San Dimas Community Hospital	San Dimas			✓	✓					
California Pacific Medical Center-St. Luke's	San Francisco		✓	✓	✓					
Kaiser Foundation Hospital-San Francisco	San Francisco	✓	✓	✓	✓					
Kaiser Foundation Hospital-San Jose	San Jose	✓	✓	✓	✓					
Regional Medical Center of San Jose	San Jose	✓	✓	✓	✓					
Kaiser Foundation Hospital-San Rafael	San Rafael	✓		✓	✓					
Kaiser Foundation Hospital-Santa Clara	Santa Clara	✓	✓	✓	✓					
Kaiser Permanente Psychiatric Health Facility-Santa Clara	Santa Clara								✓	
Dignity Health	Santa Cruz	✓	✓	✓	✓					
Sutter Maternity & Surgery Center of Santa Cruz	Santa Cruz				✓					
Saint John's Health Center	Santa Monica	✓	✓	✓	✓					
Santa Monica-UCLA Medical Center and Orthopaedic Hospital	Santa Monica	✓	✓	✓	✓					
Kaiser Foundation Hospital-Santa Rosa	Santa Rosa	✓	✓	✓	✓					
Sutter Medical Center of Santa Rosa	Santa Rosa	✓	✓	✓	✓					
Sonoma Valley Health Care District	Sonoma			✓	✓					
Sonora Community Hospital	Sonora	✓		✓						
Kaiser Foundation Hospital-South San Francisco	South San Francisco	✓	✓	✓	✓					
Dameron Hospital Association	Stockton	✓	✓	✓	✓					
St. Joseph's Medical Center of Stockton	Stockton	✓	✓	✓	✓					
Twin Cities Community Hospital	Templeton		✓	✓	✓					
Los Robles Hospital and Medical Center	Thousand Oaks	✓	✓	✓	✓					
Providence Little Company of Mary Medical Center Torrance	Torrance	✓	✓	✓	✓					
Emanuel Medical Center	Turlock	✓	✓	✓	✓					
Kaiser Foundation Hospital-Vacaville	Vacaville	✓		✓	✓					
Kaiser Foundation Hospital and Rehabilitation Center-Vallejo	Vallejo	✓	✓	✓	✓					
Sutter Solano Medical Center	Vallejo	✓	✓	✓	✓					
Watsonville Community Hospital	Watsonville			✓	✓					
Citrus Valley Medical Center	West Covina	✓	✓	✓	✓					
Presbyterian Intercommunity Hospital	Whittier	✓	✓	✓	✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immunization
Colorado										
The Medical Center of Aurora	Aurora	✓	✓	✓	✓					
Platte Valley Medical Center	Brighton	✓		✓	✓					
Colorado Mental Health Institute at Fort Logan	Denver								✓	
Rose Medical Center	Denver	✓	✓	✓	✓					
Mercy Regional Medical Center	Durango	✓		✓	✓					
Poudre Valley Hospital	Fort Collins	✓	✓	✓						
Colorado Plains Medical Center	Fort Morgan			✓	✓					
Catholic Health Initiatives Colorado	Frisco				✓					
Valley View Hospital Association	Glenwood Springs	✓		✓	✓					
Grand Junction Veterans Affairs Medical Center	Grand Junction			✓	✓					
North Colorado Medical Center	Greeley	✓	✓	✓	✓					
Exempla Good Samaritan Medical Center, LLC	Lafayette	✓	✓	✓	✓					
OrthoColorado Hospital at St. Anthony Medical Campus	Lakewood				✓					
Highlands Behavioral Health System	Littleton								✓	
HCA/HealthOne, LLC, Sky Ridge Medical Center	Lone Tree	✓		✓	✓					
Avista Adventist Hospital	Louisville			✓	✓					
Haven Behavioral War Heroes Hospital @ St. Mary-Corwin	Pueblo								✓	
Sterling Regional MedCenter	Sterling				✓					
North Suburban Medical Center	Thornton	✓		✓	✓					
Exempla Lutheran Medical Center	Wheat Ridge	✓	✓	✓	✓					
Connecticut										
St. Vincent's Medical Center	Bridgeport	✓	✓	✓	✓					
Griffin Hospital	Derby	✓	✓	✓	✓					
John Dempsey Hospital	Farmington	✓	✓	✓	✓					
Albert J. Solnit Children's Center-South Campus	Middletown								✓	
Middlesex Hospital	Middletown	✓	✓	✓	✓					
The William W. Backus Hospital	Norwich	✓	✓	✓	✓					
Day Kimball Healthcare, Inc.	Putnam	✓		✓	✓					
Saint Mary's Hospital, Inc.	Waterbury	✓	✓	✓	✓					
Delaware										
Bayhealth-Kent General Hospital	Dover	✓	✓	✓	✓					
Dover Behavioral Health System	Dover								✓	
Beebe Medical Center	Lewes	✓	✓	✓	✓					
Meadow Wood Behavioral Health System	New Castle								✓	
VA Medical Center	Wilmington				✓					
District of Columbia										
Sibley Memorial Hospital	Washington			✓	✓					
Florida										
JFK Medical Center Limited Partnership	Atlantis	✓	✓	✓	✓					
Bartow HMA, LLC	Bartow		✓	✓	✓					
Bay Pines VA Healthcare System	Bay Pines	✓	✓	✓	✓					
Boca Raton Regional Hospital, Inc.	Boca Raton	✓	✓	✓	✓					
Bethesda Hospital, Inc.	Boynton Beach	✓	✓	✓	✓					
Blake Medical Center	Bradenton	✓	✓	✓	✓					
Manatee Memorial Hospital	Bradenton	✓	✓	✓	✓					
Brandon Regional Hospital	Brandon	✓	✓	✓	✓					
Brooksville & Spring Hill Regional Hospitals	Brooksville	✓	✓	✓	✓					
Oak Hill Hospital	Brooksville	✓	✓	✓	✓					
Morton Plant Hospital Association	Clearwater	✓	✓	✓	✓					
Windmoor Healthcare of Clearwater, Inc.	Clearwater								✓	
Cape Canaveral Hospital, Inc.	Cocoa Beach	✓	✓	✓	✓					
Coral Gables Hospital	Coral Gables	✓	✓	✓	✓					
Doctors Hospital, Inc.	Coral Gables		✓	✓	✓					
Broward Health Coral Springs	Coral Springs	✓	✓	✓	✓					
North Okaloosa Medical Center	Crestview	✓	✓	✓	✓					

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Pasco Regional Medical Center	Dade City	✓	✓	✓	✓					
Heart of Florida Regional Medical Center	Davenport	✓	✓	✓	✓					
Halifax Health	Daytona Beach	✓	✓	✓	✓					
Florida Hospital Deland	Deland	✓	✓	✓	✓					
Delray Medical Center, Inc.	Delray Beach	✓	✓	✓	✓					
Mease Dunedin Hospital	Dunedin	✓	✓	✓	✓					
96th Medical Group	Eglin AFB			✓	✓		✓			
Englewood Community Hospital	Englewood			✓	✓					
South Florida Evaluation and Treatment Center (SFETC)	Florida City								✓	
Atlantic Shores Hospital	Fort Lauderdale								✓	
Broward Health Medical Center	Fort Lauderdale	✓	✓	✓	✓					
Fort Lauderdale Hospital Management, LLC	Fort Lauderdale								✓	
Holy Cross Hospital, Inc.	Fort Lauderdale	✓	✓	✓	✓					
North Broward Hospital District	Fort Lauderdale	✓	✓	✓	✓					
Lawnwood Regional Medical Center & Heart Institute	Fort Pierce	✓	✓	✓	✓	✓				
Fort Walton Beach Medical Center, Inc.	Fort Walton Beach	✓	✓	✓	✓					
North Florida Regional Medical Center	Gainesville	✓	✓	✓	✓					
Gulf Breeze Hospital	Gulf Breeze			✓	✓					
Palmetto General Hospital	Hialeah	✓	✓	✓	✓					
Hollywood Pavilion, LLC	Hollywood								✓	
Memorial Regional Hospital	Hollywood	✓	✓	✓	✓	✓			✓	
Memorial Healthcare, Inc.	Jacksonville	✓	✓	✓	✓					
River Point Behavioral Health	Jacksonville								✓	
St. Vincent's Medical Center Riverside	Jacksonville	✓	✓	✓	✓					
St. Vincent's Southside-St. Vincent's HealthCare, Inc.	Jacksonville	✓	✓	✓	✓					
Wekiva Springs Center, LLC	Jacksonville								✓	
Jupiter Medical Center	Jupiter	✓	✓	✓	✓					
Key West HMA, LLC	Key West	✓		✓	✓					
Osceola Regional Medical Center	Kissimmee	✓	✓	✓	✓					
Lake City Medical Center	Lake City		✓	✓	✓					
Largo Medical Center	Largo	✓	✓	✓	✓					
Palms West Hospital	Loxahatchee	✓	✓	✓	✓					
Northwest Medical Center	Margate	✓	✓	✓	✓					
Circles of Care, Inc.	Melbourne								✓	
Holmes Regional Medical Center, Inc.	Melbourne	✓	✓	✓	✓					
Viera Hospital, Inc.	Melbourne	✓		✓	✓					
Baptist Hospital of Miami	Miami	✓	✓	✓	✓			✓		
Kendall Regional Medical Center	Miami	✓	✓	✓	✓					
South Miami Hospital	Miami	✓	✓	✓	✓					
West Kendall Baptist Hospital	Miami	✓	✓	✓	✓					
Santa Rosa Medical Center	Milton	✓		✓	✓					
Memorial Hospital Miramar	Miramar	✓	✓	✓	✓					
Sacred Heart Hospital on the Emerald Coast	Miramar Beach	✓		✓	✓					
Twin Cities Hospital	Niceville			✓	✓					
Ocala Regional Medical Center	Ocala	✓	✓	✓	✓					
Raulerson Hospital	Okeechobee	✓	✓	✓	✓					
Florida Hospital Fish Memorial	Orange City	✓	✓	✓	✓					
Orange Park Medical Center	Orange Park	✓	✓	✓	✓					
Palm Bay Hospital	Palm Bay	✓	✓	✓	✓					
Palm Beach Gardens Medical Center	Palm Beach Gardens	✓	✓	✓	✓					
Florida Hospital Flagler	Palm Coast	✓	✓	✓	✓					
Gulf Coast Medical Center	Panama City	✓	✓	✓	✓					
Geo Care LLC South Florida State Hospital	Pembroke Pines								✓	
Memorial Hospital Pembroke	Pembroke Pines	✓	✓	✓	✓					
Memorial Hospital West	Pembroke Pines	✓	✓	✓	✓					
Naval Hospital Pensacola	Pensacola				✓		✓			
West Florida Regional Medical Center, Inc.	Pensacola	✓	✓	✓	✓					

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Plantation General Hospital	Plantation	✓	✓	✓	✓					
Westside Regional Medical Center	Plantation	✓	✓	✓	✓					
Broward Health North	Pompano Beach	✓	✓	✓	✓					
Fawcett Memorial Hospital	Port Charlotte	✓	✓	✓	✓					
St. Lucie Medical Center	Port Saint Lucie	✓	✓	✓	✓					
Charlotte Regional Medical Center	Punta Gorda	✓	✓	✓	✓					
St. Cloud Regional Medical Center	Saint Cloud		✓	✓	✓					
All Children's Hospital, Inc.	Saint Petersburg					✓				
Edward White Hospital	Saint Petersburg			✓	✓					
Northside Hospital	Saint Petersburg	✓	✓	✓	✓					
St. Petersburg General Hospital	Saint Petersburg	✓		✓	✓					
Central Florida Regional Hospital	Sanford	✓	✓	✓	✓					
Doctors Hospital of Sarasota	Sarasota	✓	✓	✓	✓					
Sebastian River Medical Center	Sebastian	✓	✓	✓	✓					
Florida Hospital Heartland Medical Center	Sebring	✓	✓	✓	✓					
Highlands Regional Medical Center	Sebring	✓	✓	✓	✓					
Shands Starke Regional Medical Center	Starke			✓						
South Bay Hospital	Sun City Center	✓	✓	✓	✓					
Capital Regional Medical Center	Tallahassee	✓	✓	✓	✓					
St. Joseph's Hospital, Inc.	Tampa	✓	✓	✓	✓					
Florida Hospital North Pinellas	Tarpon Springs	✓	✓	✓	✓					
Florida Hospital Waterman	Tavares	✓	✓	✓	✓					
Mariners Hospital	Tavernier			✓	✓					
North Brevard County Hospital District	Titusville	✓	✓	✓	✓					
Medical Center of Trinity	Trinity	✓	✓	✓	✓					
Venice HMA, LLC	Venice	✓	✓	✓	✓					
Wellington Regional Medical Center	Wellington	✓	✓	✓	✓					
West Palm Hospital	West Palm Beach			✓	✓					
Florida Hospital Zephyrhills	Zephyrhills	✓	✓	✓	✓					
Georgia										
Northside Hospital, Inc.	Atlanta		✓	✓	✓					
Wesley Woods Center of Emory University	Atlanta								✓	
Doctors Hospital of Augusta	Augusta	✓	✓	✓	✓					
Trinity Hospital of Augusta	Augusta	✓		✓	✓					
Fannin Regional Hospital	Blue Ridge			✓	✓					
Higgins General Hospital	Bremen			✓						
Gordon Hospital	Calhoun	✓	✓	✓	✓					
Northside Hospital-Cherokee	Canton		✓	✓	✓					
Tanner Medical Center, Inc.	Carrollton	✓	✓	✓	✓					
Cartersville Medical Center	Cartersville	✓	✓	✓	✓					
Hughston Hospital	Columbus				✓					
Rockdale Hospital, LLC	Conyers	✓	✓	✓	✓					
Crisp Regional Hospital, Inc.	Cordele	✓	✓	✓	✓					
Northside Hospital-Forsyth	Cumming		✓	✓	✓					
Georgia Regional Hospital at Atlanta	Decatur								✓	
Coffee Regional Medical Center	Douglas		✓	✓	✓					
Fairview Park Hospital	Dublin	✓	✓	✓	✓					
VA Medical Center-Carl Vinson	Dublin			✓						
West Georgia Medical Center, Inc.	Lagrange	✓	✓	✓	✓					
Gwinnett Medical Center	Lawrenceville	✓	✓	✓	✓					
Coliseum Medical Centers	Macon	✓	✓	✓	✓					
Coliseum Northside Hospital	Macon			✓	✓					
Coliseum Psychiatric Center, LLC	Macon								✓	
Colquitt Regional Medical Center	Moultrie		✓	✓	✓					
Perry Hospital	Perry			✓	✓					
RiverWoods Behavioral Health System, LLC	Riverdale								✓	
Redmond Park Hospital, LLC	Rome	✓	✓	✓	✓					

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North Fulton Medical Center, Inc.	Roswell	✓	✓	✓	✓					
Georgia Regional Hospital at Savannah	Savannah								✓	
Emory-Adventist Hospital	Smyrna			✓	✓					
Ridgeview Institute	Smyrna								✓	
John D. Archbold Memorial Hospital	Thomasville	✓	✓	✓	✓					
Southwestern State Hospital	Thomasville								✓	
Tanner Medical Center/Villa Rica	Villa Rica	✓		✓	✓					
Barrow Regional Medical Center	Winder			✓	✓					
Hawaii										
Sutter Health Pacific	Ewa Beach								✓	
Kaiser Foundation Hospital	Honolulu	✓	✓	✓	✓					
The Queen's Medical Center	Honolulu	✓	✓	✓	✓					
Castle Medical Center	Kailua	✓	✓	✓						
Idaho										
State Hospital South	Blackfoot								✓	
Saint Alphonsus Regional Medical Center	Boise	✓	✓	✓	✓					
West Valley Medical Center	Caldwell	✓		✓	✓					
Eastern Idaho Health Services	Idaho Falls	✓	✓	✓	✓					
Saint Alphonsus Medical Center-Nampa	Nampa	✓	✓	✓	✓					
St. Luke's Magic Valley Medical Center	Twin Falls	✓	✓	✓	✓					
Illinois										
Alton Memorial Hospital	Alton	✓	✓	✓	✓					
Saint Anthony's Health Center	Alton	✓		✓	✓					
St. Elizabeth's Hospital	Belleville	✓	✓	✓	✓					
MacNeal Hospital	Berwyn	✓	✓	✓	✓					
MetroSouth Medical Center	Blue Island	✓	✓	✓						
St. Mary's Hospital	Centralia	✓		✓	✓					
The Pavilion Foundation	Champaign								✓	
Chester Mental Health Center	Chester								✓	
Advocate Illinois Masonic Medical Center	Chicago	✓	✓	✓	✓					
Ann & Robert H. Lurie Children's Hospital of Chicago	Chicago					✓				
Aurora Chicago Lakeshore Hospital	Chicago								✓	
Louis A. Weiss Memorial Hospital	Chicago	✓	✓	✓	✓					
Rush University Medical Center	Chicago	✓	✓	✓	✓					
Kishwaukee Community Hospital	Dekalb	✓	✓	✓	✓					
Presence Saint Joseph Hospital-Elgin	Elgin	✓		✓	✓					
Alexian Brothers Medical Center	Elk Grove Village	✓	✓	✓	✓					
Little Company of Mary Hospital	Evergreen Park	✓	✓	✓	✓	✓				
Clay County Hospital	Flora			✓						
Riveredge Hospital	Forest Park								✓	
Gibson Community Hospital	Gibson City				✓					
Granite City Illinois Hospital Company, LLC	Granite City	✓	✓	✓	✓					
Adventist La Grange Memorial Hospital	La Grange	✓	✓	✓	✓					
VA Medical Center	Marion			✓						
Gottlieb Memorial Hospital	Melrose Park	✓	✓	✓	✓					
Silver Cross Hospital	New Lenox	✓	✓	✓	✓					
Ottawa Regional Hospital and Healthcare Center	Ottawa			✓	✓					
OSF Saint Francis Medical Center	Peoria	✓	✓	✓	✓					
The Methodist Medical Center of Illinois	Peoria	✓	✓	✓	✓					
OSF Saint James-John W. Albrecht Medical Center	Pontiac			✓	✓					
Blessing Hospital	Quincy	✓	✓	✓	✓					
Red Bud Regional Hospital, LLC	Red Bud			✓	✓					
Valley West Community Hospital	Sandwich			✓	✓					
Genesis Medical Center, Illini Campus	Silvis		✓	✓	✓					
St. Mary's Hospital	Streator			✓	✓					
CTCA at Midwestern Regional Medical Center	Zion				✓					

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Indiana										
St. Vincent Anderson Regional Hospital	Anderson	✓	✓	✓	✓					
Bloomington Meadows Hospital	Bloomington								✓	
Bluffton Regional Medical Center	Bluffton			✓	✓					
St. Catherine Hospital, Inc.	East Chicago	✓	✓	✓	✓					
Evansville State Hospital	Evansville								✓	
Dupont Hospital, LLC	Fort Wayne			✓	✓					
Lutheran Hospital of Indiana	Fort Wayne	✓	✓	✓	✓					
Orthopaedic Hospital at Parkview North	Fort Wayne				✓					
The Orthopedic Hospital of Lutheran Health Network	Fort Wayne				✓					
VA Northern Indiana Health Care System	Fort Wayne			✓						
St. Vincent Frankfort Hospital	Frankfort			✓						
Valle Vista Health System	Greenwood								✓	
Huntington Memorial Hospital	Huntington			✓	✓					
Larue D. Carter Memorial Hospital	Indianapolis								✓	
Wishard Health Services	Indianapolis	✓	✓	✓	✓					
Wellstone Regional Hospital Acquisition, LLC	Jeffersonville								✓	
Parkview Noble Hospital	Kendallville			✓	✓					
St. Joseph Hospital & Health Center, Inc.	Kokomo		✓	✓	✓					
Logansport State Hospital	Logansport								✓	
Madison State Hospital	Madison								✓	
Indiana University Health Morgan Hospital	Martinsville			✓						
Saint Joseph Regional Medical Center	Mishawaka	✓	✓	✓	✓					
Indiana University Health Ball Memorial Hospital, Inc.	Muncie	✓	✓	✓	✓					
Brentwood Meadows, LLC	Newburgh								✓	
Dukes Memorial Hospital	Peru			✓						
HHC Indiana, Inc.	Plymouth								✓	
Gibson General Hospital, Inc.	Princeton			✓						
Harsha Behavioral Center, Inc.	Terre Haute								✓	
Terre Haute Regional Hospital	Terre Haute	✓	✓	✓	✓					
Kosciusko Community Hospital	Warsaw	✓	✓	✓	✓					
Iowa										
Mary Greeley Medical Center	Ames	✓	✓	✓	✓					
Sartori Memorial Hospital-Wheaton Franciscan Healthcare	Cedar Falls			✓	✓					
Mercy Medical Center, Cedar Rapids, Iowa	Cedar Rapids	✓	✓	✓	✓					
Mercy Medical Center-Clinton	Clinton	✓	✓	✓	✓					
Genesis Medical Center, Davenport	Davenport	✓	✓	✓	✓					
Mercy Medical Center	Des Moines	✓	✓	✓	✓					
Mental Health Institute	Independence								✓	
The University of Iowa Hospitals and Clinics	Iowa City	✓	✓	✓	✓					
Allen Memorial Hospital	Waterloo	✓	✓	✓	✓					
Covenant Medical Center-Wheaton Franciscan Healthcare-Iowa	Waterloo	✓		✓	✓					
Great River Medical Center	West Burlington	✓	✓	✓	✓					
Kansas										
Allen County Hospital	Iola			✓						
Rainbow Mental Health Facility	Kansas City								✓	
Lawrence Memorial Hospital	Lawrence	✓		✓	✓					
Saint John Hospital	Leavenworth			✓						
Osawatomie State Hospital	Osawatomie								✓	
Miami County Medical Center, Inc.	Paola				✓					
Shawnee Mission Medical Center	Shawnee Mission	✓	✓	✓	✓					
Stormont-Vail HealthCare, Inc.	Topeka	✓	✓	✓	✓					
Via Christi Hospital Wichita St. Teresa, Inc.	Wichita			✓	✓					
Wesley Medical Center, LLC	Wichita	✓	✓	✓	✓	✓				

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Kentucky										
Ashland Hospital Corporation	Ashland	✓	✓	✓	✓					
Flaget Healthcare, Inc.	Bardstown			✓	✓					
Saint Joseph Berea	Berea			✓	✓					
Greenview Regional Hospital	Bowling Green			✓	✓					
Rivendell Behavioral Health Services of Kentucky	Bowling Green								✓	
Ephraim McDowell Regional Medical Center, Inc.	Danville	✓	✓	✓	✓					
Saint Elizabeth Medical Center, Inc.	Edgewood	✓	✓	✓	✓					
Saint Elizabeth Medical Center, Inc.	Fort Thomas	✓	✓	✓	✓					
Frankfort Regional Medical Center	Frankfort	✓	✓	✓	✓					
Parkway Regional Hospital	Fulton			✓	✓					
Harlan Appalachian Regional Hospital	Harlan		✓	✓	✓					
ABS LINCS KY, Inc.	Hopkinsville								✓	
Western State Hospital	Hopkinsville								✓	
Spring View Hospital	Lebanon			✓	✓					
Twin Lakes Regional Medical Center	Leitchfield			✓	✓					
Saint Joseph East	Lexington	✓	✓	✓	✓					
University of Kentucky Hospital	Lexington	✓	✓	✓	✓	✓				
Hospital of Louisa, Inc.	Louisa			✓	✓					
Middlesboro ARH Hospital	Middlesboro		✓	✓						
Saint Joseph Health System, Inc.	Mount Sterling			✓	✓					
Owensboro Health, Inc.	Owensboro	✓	✓	✓	✓					
Baptist Healthcare System, Inc.	Paducah	✓	✓	✓	✓					
Paul B. Hall Regional Medical Center	Paintsville			✓						
Bourbon Community Hospital	Paris			✓						
Logan Memorial Hospital	Russellville			✓						
Louisiana										
Oceans Behavioral Hospital of Alexandria	Alexandria								✓	
Rapides Regional Medical Center	Alexandria	✓	✓	✓	✓					
Earl K. Long Medical Center	Baton Rouge	✓	✓	✓	✓					
Woman's Hospital	Baton Rouge				✓					
Washington St. Tammany Regional Medical Center	Bogalusa		✓	✓	✓					
Oceans Behavioral Hospital of Lafayette	Broussard								✓	
Lakeview Regional Medical Center	Covington	✓	✓	✓	✓					
Oceans Behavioral Hospital-Deridder	Deridder								✓	
Southern Regional Medical Corporation	Houma	✓	✓	✓	✓					
Oceans Behavioral Hospital of Greater New Orleans	Kenner								✓	
Heart Hospital of Lafayette	Lafayette	✓			✓					
Lafayette General Medical Center, Inc.	Lafayette	✓	✓	✓						
The Regional Medical Center of Acadiana	Lafayette	✓	✓	✓	✓					
MBH of Louisiana, LLC	Mandeville								✓	
Minden Medical Center	Minden	✓	✓	✓	✓					
Progressive Acute Care Dauterive, LLC	New Iberia	✓		✓	✓					
Oceans Behavioral Hospital of Opelousas	Opelousas								✓	
Central Louisiana State Hospital	Pineville								✓	
Ochsner St. Anne General Hospital	Raceland			✓	✓					
Phoenix Behavioral Hospital of Eunice	Rayne								✓	
Ruston Louisiana Hospital Company, LLC	Ruston	✓	✓	✓	✓					
Maine										
MaineGeneral Medical Center	Augusta	✓	✓	✓	✓					
Southern Maine Medical Center	Biddeford	✓	✓	✓	✓					
Mid Coast Hospital	Brunswick	✓	✓	✓	✓					
Cary Medical Center	Caribou			✓	✓					
Maine Coast Memorial Hospital	Ellsworth	✓		✓	✓					
Franklin Memorial Hospital	Farmington			✓	✓					
Northern Maine Medical Center	Fort Kent			✓						
Sebasticook Valley Health	Pittsfield			✓						

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Maine Medical Center	Portland	✓	✓	✓	✓					
Mercy Hospital	Portland	✓		✓	✓					
Henrietta D. Goodall Hospital	Sanford			✓	✓					
Maryland										
Maryland General Hospital	Baltimore		✓	✓	✓					
The Johns Hopkins Hospital	Baltimore	✓	✓	✓	✓					
Upper Chesapeake Medical Center	Bel Air	✓	✓	✓	✓					
Spring Grove Hospital Center	Catonsville								✓	
Thomas B. Finan Center	Cumberland								✓	
Frederick Memorial Hospital	Frederick	✓	✓	✓	✓					
Brook Lane Health Services	Hagerstown								✓	
Harford Memorial Hospital	Havre De Grace			✓	✓					
Clifton T. Perkins Hospital Center	Jessup								✓	
Civista Medical Center, Inc.	La Plata		✓	✓	✓					
Doctors Community Hospital	Lanham	✓	✓	✓	✓					
MedStar Montgomery Medical Center	Olney	✓	✓	✓	✓					
Calvert Memorial Hospital	Prince Frederick	✓	✓	✓	✓					
Shady Grove Adventist Hospital	Rockville	✓	✓	✓	✓					
Holy Cross Hospital of Silver Spring, Inc.	Silver Spring	✓	✓	✓	✓					
Washington Adventist Hospital	Takoma Park	✓	✓	✓	✓					
Massachusetts										
Sturdy Memorial Hospital, Inc.	Attleboro	✓	✓	✓	✓					
Northeast Hospital Corporation	Beverly	✓	✓	✓	✓					
Beth Israel Deaconess Medical Center	Boston	✓	✓	✓	✓					
Brigham and Women's Faulkner Hospital	Boston		✓	✓	✓					
Franciscan Hospital for Children, Inc.	Boston								✓	
New England Baptist Hospital	Boston				✓					
Signature-Healthcare Brockton Hospital	Brockton	✓	✓	✓	✓					
Steward Carney Hospital, Inc.	Dorchester		✓	✓	✓					
Falmouth Hospital	Falmouth	✓		✓	✓					
MetroWest Medical Center	Framingham	✓	✓	✓	✓					
Fairview Hospital	Great Barrington			✓	✓					
Beth Israel Deaconess Hospital-Milton	Milton			✓	✓					
Newton-Wellesley Hospital	Newton Lower Falls	✓	✓	✓	✓					
North Adams Regional Hospital	North Adams			✓	✓					
Berkshire Medical Center	Pittsfield	✓	✓	✓	✓					
Walden Behavioral Care	Waltham								✓	
Noble Hospital	Westfield			✓	✓					
VHS Acquisition Subsidiary Number 7, Inc.	Worcester	✓	✓	✓	✓					
Michigan										
St. Joseph Mercy Hospital	Ann Arbor	✓	✓	✓	✓					
The University of Michigan Hospitals and Health Centers	Ann Arbor	✓	✓	✓	✓					
Mecosta County Medical Center	Big Rapids			✓	✓					
Caro Center	Caro								✓	
MidMichigan Medical Center-Clare	Clare			✓	✓					
BCA of Detroit, LLC	Detroit								✓	
Detroit Receiving Hospital and University Health Center	Detroit	✓	✓	✓	✓					
Borgess-Lee Memorial Hospital	Dowagiac			✓						
Newaygo County General Hospital Association	Fremont			✓	✓					
MidMichigan Medical Center Gladwin	Gladwin			✓						
Forest View Psychiatric Hospital	Grand Rapids								✓	
Beaumont Hospital, Grosse Pointe	Grosse Pointe	✓	✓	✓	✓					
WA Foote Memorial Hospital	Jackson	✓	✓	✓	✓					
Kalamazoo Psychiatric Hospital	Kalamazoo								✓	
Aspirus Keweenaw Hospital	Laurium			✓	✓					
St. Mary Mercy Hospital	Livonia	✓	✓	✓	✓					
Mercy Memorial Hospital System	Monroe	✓	✓	✓	✓					

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St. Joseph Mercy Oakland	Pontiac	✓	✓	✓	✓			✓		
St. Joseph Mercy Port Huron	Port Huron	✓	✓	✓	✓					
Spectrum Health Reed City Hospital	Reed City			✓						
William Beaumont Hospital	Royal Oak	✓	✓	✓	✓					
South Haven Community Hospital, Authority	South Haven			✓	✓					
Straith Hospital for Special Surgery	Southfield									✓
Oakwood Heritage Hospital	Taylor	✓	✓	✓	✓					
William Beaumont Hospital	Troy	✓	✓	✓	✓					
Walter P. Reuther Psychiatric Hospital	Westland								✓	
Spectrum Health Zeeland Community Hospital	Zeeland			✓	✓					
Minnesota										
Mayo Clinic Health System-Austin	Austin		✓	✓	✓					
Cambridge Medical Center	Cambridge			✓	✓					
Fairview Southdale Hospital	Edina	✓	✓	✓	✓					
Unity Hospital	Fridley	✓	✓	✓	✓					
VA Health Care System-Minneapolis	Minneapolis	✓	✓	✓	✓					
New Ulm Medical Center	New Ulm			✓	✓					
Owatonna Hospital	Owatonna			✓	✓					
St. Joseph's Area Health Services	Park Rapids				✓					
Fairview Northland Health Services	Princeton			✓	✓					
Mayo Clinic Health System in Red Wing	Red Wing			✓	✓					
Regions Hospital	Saint Paul	✓	✓	✓	✓					
St. Francis Regional Medical Center	Shakopee			✓	✓					
Lakeview Memorial Hospital	Stillwater				✓					
Child and Adolescent Behavioral Health Services	Willmar								✓	
Woodwinds Health Campus	Woodbury			✓	✓					
Fairview Lakes Medical Center	Wyoming			✓	✓					
Mississippi										
Amory HMA, LLC	Amory		✓	✓	✓					
Hancock Medical Center	Bay Saint Louis		✓	✓	✓					
81st Medical Group	Biloxi		✓		✓					
Biloxi Regional Medical Center	Biloxi		✓	✓	✓					
Baptist Memorial Hospital-Booneville	Booneville			✓						
Bolivar Medical Center	Cleveland			✓	✓					
Baptist Memorial Hospital-Golden Triangle	Columbus	✓	✓	✓	✓					
Garden Park Medical Center	Gulfport		✓	✓	✓					
Wesley Health System, LLC	Hattiesburg	✓	✓	✓	✓					
River Oaks Hospital, LLC	Jackson			✓	✓					
Woman's Hospital	Jackson				✓					
Alliance Health Center, Inc.	Meridian								✓	
Natchez Community Hospital	Natchez		✓	✓	✓					
Baptist Memorial Hospital-Union County	New Albany		✓	✓						
Baptist Memorial Hospital-North Mississippi	Oxford	✓	✓	✓	✓					
River Region Medical Center	Vicksburg	✓	✓	✓	✓					
Missouri										
Belton Regional Medical Center	Belton			✓	✓					
SSM DePaul Health Center	Bridgeton	✓	✓	✓	✓					
Harry S. Truman Memorial Veterans' Hospital	Columbia	✓	✓	✓	✓					
University of Missouri Health Care	Columbia	✓	✓	✓	✓					
SSM St. Clare Health Center	Fenton	✓	✓	✓	✓					
Cass Regional Medical Center	Harrisonville			✓	✓				✓	
Centerpoint Medical Center of Independence, LLC	Independence	✓	✓	✓	✓					
St. Mary's Health Center	Jefferson City	✓	✓	✓	✓					
Research Medical Center	Kansas City	✓	✓	✓	✓					
Research Psychiatric Center	Kansas City								✓	
SSM St. Joseph Hospital West	Lake Saint Louis	✓	✓	✓	✓					
Lee's Summit Medical Center	Lee's Summit	✓	✓	✓	✓					

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Lafayette Regional Health Center	Lexington			✓	✓					
Moberly Hospital Company, LLC	Moberly	✓		✓	✓					
Perry County Memorial Hospital	Perryville			✓	✓					
John J. Pershing VA Medical Center	Poplar Bluff			✓						
SSM St. Mary's Health Center	Richmond Heights	✓	✓	✓	✓	✓				
SSM St. Joseph Health Center	Saint Charles	✓	✓	✓	✓					
Heartland Regional Medical Center	Saint Joseph	✓	✓	✓	✓					
Northwest Missouri Psychiatric Rehabilitation Center	Saint Joseph								✓	
Hawthorn Children's Psychiatric Hospital	Saint Louis								✓	
Saint Louis University Hospital	Saint Louis	✓	✓	✓	✓					
St. Louis VA Healthcare System	Saint Louis	✓	✓	✓	✓					
Lincoln County Medical Center	Troy			✓	✓					
Mercy Hospital Washington	Washington	✓	✓	✓	✓					
Royal Oaks Hospital	Windsor								✓	
Montana										
St. Vincent Healthcare	Billings	✓	✓	✓	✓					
Bozeman Deaconess Hospital	Bozeman	✓		✓	✓					
Holy Rosary Healthcare	Miles City			✓	✓					
St. Patrick Hospital	Missoula	✓	✓	✓	✓					
Providence St. Joseph Medical Center	Polson				✓					
Nebraska										
Bellevue Medical Center	Bellevue	✓		✓	✓					
Columbus Community Hospital, Inc.	Columbus			✓	✓					
Lincoln Regional Center	Lincoln								✓	
Community Hospital	McCook				✓					
Alegent Creighton Health Creighton University Medical Center	Omaha	✓	✓	✓	✓					
Regional West Medical Center	Scottsbluff	✓		✓						
Nevada										
Sierra Surgery Hospital	Carson City				✓					
Northeastern Nevada Regional Hospital	Elko			✓	✓					
Banner Churchill Community Hospital	Fallon			✓	✓					
St. Rose Dominican Hospitals-Rose de Lima Campus	Henderson	✓	✓	✓	✓					
Red Rock Behavioral Health Hospital	Las Vegas								✓	
SBH-Montevista Hospital	Las Vegas								✓	
Southern Hills Medical Center, LLC	Las Vegas	✓	✓	✓	✓					
Spring Mountain Treatment Center	Las Vegas								✓	
Sunrise MountainView Hospital	Las Vegas	✓	✓	✓	✓					
Mesa View Regional Hospital	Mesquite			✓	✓					
Renown Regional Medical Center	Reno	✓	✓	✓	✓	✓				
Renown South Meadows Medical Center	Reno			✓	✓					
VA Sierra Nevada Health Care System	Reno		✓	✓	✓					
Northern Nevada Adult Mental Health Services	Sparks								✓	
Northern Nevada Medical Center	Sparks	✓		✓	✓					
New Hampshire										
New Hampshire Hospital	Concord								✓	
Hampstead Hospital	Hampstead								✓	
Catholic Medical Center	Manchester	✓	✓	✓	✓					
Elliot Hospital	Manchester	✓	✓	✓	✓					
Southern New Hampshire Medical Center	Nashua	✓	✓	✓	✓			✓		
St. Joseph Hospital of Nashua New Hampshire	Nashua	✓	✓	✓	✓					
Portsmouth Regional Hospital	Portsmouth	✓	✓	✓	✓					
New Jersey										
AtlantiCare Regional Medical Center	Atlantic City	✓	✓	✓				✓		
Clara Maass Medical Center	Belleville	✓	✓	✓	✓					
Camden County Health Services Center	Blackwood								✓	
Our Lady of Lourdes Medical Center	Camden	✓	✓	✓	✓					

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The Cooper Health System	Camden	✓	✓	✓	✓					
Cape Regional Medical Center	Cape May Court House	✓	✓	✓	✓					
Englewood Hospital and Medical Center	Englewood	✓	✓	✓	✓					
Hackettstown Regional Medical Center	Hackettstown	✓		✓	✓					
Ancora Psychiatric Hospital	Hammonton								✓	
Bayshore Community Hospital	Holmdel	✓	✓	✓	✓					
Kimball Medical Center	Lakewood	✓	✓	✓	✓					
Greystone Park Psychiatric Hospital	Morris Plains								✓	
Saint Peter's University Hospital	New Brunswick	✓	✓	✓	✓	✓				
Newark Beth Israel Medical Center	Newark	✓	✓	✓	✓					
St. Mary's Hospital	Passaic	✓	✓	✓	✓					
Capital Health Medical Center-Hopewell	Pennington	✓	✓		✓			✓		
St. Luke's Warren Hospital Inc.	Phillipsburg	✓	✓	✓	✓					
Princeton HealthCare System	Plainsboro	✓	✓	✓	✓					
Forrest S. Chilton III Memorial Hospital, Inc.	Pompton Plains	✓	✓	✓	✓					
Valley Health System	Ridgewood	✓	✓	✓	✓					
Hudson County Meadowview Psychiatric Hospital	Secaucus								✓	
Shore Medical Center	Somers Point	✓	✓	✓	✓					
Holy Name Medical Center	Teaneck	✓	✓	✓	✓					
Ann Klein Forensic Center	Trenton								✓	
Capital Health System, Inc.	Trenton	✓	✓		✓			✓		
Christian Health Care Center	Wyckoff								✓	
New Mexico										
Carlsbad Medical Center	Carlsbad		✓	✓	✓					
Plains Regional Medical Center	Clovis			✓	✓					
Lea Regional Hospital, LLC	Hobbs		✓	✓	✓					
Memorial Medical Center	Las Cruces	✓	✓	✓						
Roswell Hospital Corporation	Roswell	✓		✓	✓					
Lincoln County Medical Center	Ruidoso			✓	✓					
Strategic Behavioral Health El Paso, LLC	Santa Teresa								✓	
New York										
Brunswick Hospital Center	Amityville								✓	
St. Mary's Healthcare	Amsterdam	✓	✓	✓	✓					
VA Healthcare Network Upstate New York at Bath	Bath			✓						
Bronx Psychiatric Center	Bronx								✓	
North Central Bronx Hospital	Bronx		✓	✓						
Kingsboro Psychiatric Center	Brooklyn								✓	
Lutheran Medical Center	Brooklyn	✓	✓	✓	✓					
New York Community Hospital	Brooklyn	✓	✓	✓	✓					
The Brooklyn Hospital Center	Brooklyn	✓	✓	✓	✓					
Sisters of Charity Hospital	Buffalo	✓	✓	✓	✓					
F. F. Thompson Hospital	Canandaigua	✓		✓	✓					
The Mary Imogene Bassett Hospital and Clinics	Cooperstown	✓	✓	✓						
Elmira Psychiatric Center	Elmira								✓	
Forest Hills Hospital	Forest Hills	✓	✓	✓	✓					
Geneva General Hospital	Geneva			✓	✓					
Community Memorial Hospital	Hamilton			✓	✓					
United Health Services Hospitals, Inc.	Johnson City	✓	✓		✓					
HealthAlliance of the Hudson Valley, Mary's Avenue Campus	Kingston				✓					
Central New York Psychiatric Center	Marcy								✓	
Schuyler Hospital, Inc.	Montour Falls			✓						
VA Hudson Valley Health Care System	Montrose								✓	
Northern Westchester Hospital	Mount Kisco		✓	✓	✓					
Mid-Hudson Forensic Psychiatric Center	New Hampton								✓	
Kirby Forensic Psychiatric Center	New York								✓	

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Manhattan Psychiatric Center	New York								✓	
New York Gracie Square Hospital	New York								✓	
NYU Hospitals Center	New York	✓	✓	✓	✓					
St. Luke's-Roosevelt Hospital Center	New York	✓	✓	✓	✓					
Nyack Hospital	Nyack	✓	✓	✓	✓					
South Nassau Communities Hospital	Oceanside	✓	✓	✓	✓					
Rockland Psychiatric Center	Orangeburg								✓	
St. Charles Hospital	Port Jefferson			✓	✓			✓		
Vassar Brothers Medical Center	Poughkeepsie	✓	✓	✓	✓					
Northern Dutchess Hospital	Rhinebeck			✓	✓					
Mercy Medical Center	Rockville Centre	✓	✓	✓	✓					
Ellis Medicine Ellis Hospital	Schenectady	✓	✓	✓	✓					
South Beach Psychiatric Center	Staten Island								✓	
Staten Island University Hospital	Staten Island	✓	✓	✓	✓					
Hutchings Psychiatric Center	Syracuse								✓	
St. Anthony Community Hospital	Warwick			✓	✓					
Jones Memorial Hospital	Wellsville			✓	✓					
Pilgrim Psychiatric Center	West Brentwood								✓	
Western New York Children's Psychiatric Center	West Seneca								✓	
White Plains Hospital Center	White Plains	✓	✓	✓	✓					
St. Joseph's Hospital	Yonkers	✓	✓	✓	✓					
North Carolina										
East Carolina Health	Ahoskie		✓	✓	✓					
Randolph Hospital, Inc.	Asheboro	✓	✓	✓	✓					
Mission Health System	Asheville			✓	✓					
Brunswick Community Hospital	Bolivia		✓	✓	✓			✓		✓
Carolinas Medical Center-Mercy & Carolinas Medical Center-Pineville	Charlotte	✓	✓	✓	✓					
NH Charlotte Orthopaedic Hospital	Charlotte				✓					✓
CMC-NorthEast	Concord	✓	✓	✓	✓	✓				
Duke University Hospital	Durham	✓	✓	✓	✓					
Durham Regional Hospital	Durham	✓	✓	✓	✓					
Cherry Hospital	Goldsboro								✓	
Wayne Memorial Hospital, Inc.	Goldsboro	✓	✓	✓	✓					
Moses H. Cone Memorial Hospital	Greensboro	✓	✓	✓	✓					
Brynn Marr Hospital	Jacksonville								✓	
Duplin General Hospital, Inc.	Kenansville		✓	✓	✓					
Kings Mountain Hospital	Kings Mountain			✓						
Scotland Health Care System	Laurinburg	✓	✓	✓	✓					
Caldwell Memorial Hospital, Inc.	Lenoir			✓	✓					
Carolinas Medical Center-Lincoln	Lincolnton		✓	✓	✓					
The McDowell Hospital	Marion		✓	✓	✓					
Carolinas Medical Center-Union	Monroe	✓	✓	✓	✓					
Lake Norman Regional Medical Center	Mooresville	✓	✓	✓	✓					
Blue Ridge HealthCare Hospitals, Inc.	Morganton	✓	✓	✓	✓					
Southwestern Health System, Inc.	Murphy			✓	✓					
The Outer Banks Hospital	Nags Head			✓	✓					
Wilkes Regional Medical Center	North Wilkesboro			✓	✓					
Duke Raleigh Hospital	Raleigh	✓	✓	✓	✓					
Rex Healthcare	Raleigh	✓	✓	✓	✓					
Davis Regional Medical Center	Statesville			✓	✓					
WestCare Health System	Sylva		✓	✓	✓					
East Carolina Health-Heritage, Inc.	Tarboro		✓	✓	✓					
Carolinas Anson Healthcare, Inc.	Wadesboro			✓						
Medical Park Hospital, Inc.	Winston Salem				✓					✓

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North Dakota										
Saint Alexius Medical Center	Bismarck	✓	✓	✓	✓					
Sanford Medical Center Bismarck	Bismarck	✓	✓	✓	✓					
Fargo VA Health Care System	Fargo			✓	✓					
North Dakota State Hospital	Jamestown								✓	
Ohio										
Crystal Clinic Orthopaedic Center, LLC	Akron				✓					
Mercy Health-Clermont Hospital	Batavia		✓	✓	✓					
Univeristy Hospitals Geauga Medical Center	Chardon	✓	✓	✓	✓					
Mercy Hospital Anderson	Cincinnati	✓	✓	✓	✓					
Berger Hospital	Circleville			✓	✓					
Mercer County Joint Township Community Hospital	Coldwater			✓	✓					
Doctors Hospital	Columbus	✓	✓	✓	✓					
Grant Medical Center	Columbus	✓	✓	✓	✓					
Ohio Hospital for Psychiatry	Columbus								✓	
Riverside Methodist Hospital	Columbus	✓	✓	✓	✓					
The Ohio State University Hospital	Columbus	✓	✓	✓	✓					
Twin Valley Behavioral Healthcare	Columbus								✓	
Department of Veterans Affairs Medical Center, Dayton, Ohio	Dayton		✓	✓	✓					
Miami Valley Hospital (Main Site), Dayton OH	Dayton	✓	✓	✓	✓					
Mercy Hospital of Defiance, LLC	Defiance			✓	✓					
Grady Memorial Hospital	Delaware			✓	✓					
Ten Lakes Center, LLC	Dennison								✓	
Dublin Methodist Hospital	Dublin			✓	✓					
Euclid Hospital	Euclid		✓	✓	✓					
Atrium Medical Center	Franklin	✓	✓	✓	✓			✓		
Marymount Hospital	Garfield Heights	✓	✓	✓	✓					
University Hospitals Geneva Medical Center	Geneva			✓	✓					
Marion General Hospital, Inc.	Marion	✓	✓	✓	✓					
Craig and Frances Lindner Center of HOPE	Mason								✓	
Heartland Behavioral Healthcare	Massillon								✓	
Arrowhead Behavioral Health	Maumee								✓	
Southwest General Health Center	Middleburg Heights	✓	✓	✓	✓					
Joel Pomerene Memorial Hospital	Millersburg			✓	✓					
Licking Memorial Hospital	Newark	✓	✓	✓	✓					
Northcoast Behavioral Healthcare	Northfield								✓	
Allen Medical Center	Oberlin			✓	✓					
Bay Park Community Hospital	Oregon			✓	✓					
Lake Health	Painesville	✓	✓	✓	✓					
Southern Ohio Medical Center	Portsmouth	✓	✓	✓	✓					
Upper Valley Medical Center	Troy	✓	✓	✓	✓					
The Surgery Center at Southwoods, LLC	Youngstown				✓					
Oklahoma										
INTEGRIS Blackwell Regional Hospital	Blackwell			✓						
Marshall County HMA, LLC	Madill			✓						
Jack C. Montgomery VA Medical Center	Muskogee		✓	✓	✓					
INTEGRIS Baptist Medical Center	Oklahoma City	✓	✓	✓	✓					
Kay County Oklahoma Hospital Company, LLC	Ponca City		✓	✓	✓					
INTEGRIS Mayes County Medical Center	Pryor				✓					
AHS Southcrest Hospital, LLC	Tulsa	✓	✓	✓	✓					
Universal Health Services, Inc.	Tulsa								✓	
Woodward Regional Hospital	Woodward			✓	✓					
Oregon										
Kaiser Sunnyside Medical Center	Clackamas	✓	✓	✓	✓					
Peace Harbor Hospital	Florence			✓	✓					
Willamette Valley Medical Center	McMinnville	✓		✓	✓					

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Portland VA Medical Center	Portland	✓	✓	✓	✓					
Mercy Medical Center	Roseburg	✓	✓	✓	✓					
McKenzie-Willamette Regional Medical Center Associates, LLC	Springfield	✓	✓	✓	✓					
Pennsylvania										
CH Hospital of Allentown, LLC	Allentown				✓					
Lehigh Valley Hospital	Allentown	✓	✓	✓	✓					
Sacred Heart Hospital	Allentown	✓		✓	✓					
James E. Van Zandt VA Medical Center	Altoona			✓						
St. Luke's Hospital	Bethlehem	✓	✓	✓	✓					
Bryn Mawr Hospital	Bryn Mawr	✓	✓	✓	✓					
Holy Spirit Hospital	Camp Hill	✓	✓	✓	✓					
Clarion Psychiatric Center	Clarion								✓	
St. Luke's Hospital-Miners Campus	Coaldale			✓	✓					
Coatesville Hospital Corporation	Coatesville	✓	✓	✓	✓					
Charles Cole Memorial Hospital	Coudersport			✓	✓					
Delaware County Memorial Hospital	Drexel Hill	✓		✓	✓					
Ephrata Community Hospital	Ephrata			✓	✓					
UPMC Bedford Memorial	Everett			✓	✓					
Gettysburg Hospital	Gettysburg		✓	✓	✓					
UPMC Horizon	Greenville	✓	✓	✓	✓					
Hanover Hospital, Inc.	Hanover	✓	✓	✓	✓					
Pinnacle Health Hospitals	Harrisburg	✓	✓	✓	✓					
First Hospital	Kingston								✓	
St. Mary Medical Center	Langhorne	✓	✓	✓	✓					
The Good Samaritan Hospital	Lebanon	✓	✓	✓	✓					
Heart of Lancaster Regional Medical Center	Lititz			✓	✓					
Lock Haven Hospital and Haven Skilled Rehab & Nursing	Lock Haven			✓	✓					
UPMC McKeesport	McKeesport	✓	✓	✓	✓					
Riddle Memorial Hospital	Media	✓	✓	✓	✓					
Alle-Kiski Medical Center	Natrona Heights	✓	✓	✓	✓					
Montgomery County Emergency Service, Inc.	Norristown								✓	
Aria Health	Philadelphia	✓	✓	✓	✓					
Friends Behavioral Health System, LP	Philadelphia								✓	
Kirkbride Center	Philadelphia								✓	
Nazareth Hospital	Philadelphia	✓	✓	✓	✓					
Presbyterian Medical Center of the UPHS	Philadelphia	✓	✓	✓	✓					
Prime Healthcare Services-Roxborough, LLC	Philadelphia		✓	✓	✓					
St. Christopher's Hospital for Children	Philadelphia					✓				
Temple University Hospital, Inc.	Philadelphia	✓	✓	✓	✓					
St. Clair Memorial Hospital	Pittsburgh	✓	✓	✓	✓					
UPMC Mercy	Pittsburgh	✓	✓	✓	✓					
UPMC Passavant	Pittsburgh	✓	✓	✓	✓					
Pottstown Memorial Medical Center	Pottstown	✓	✓	✓	✓					
St. Luke's Quakertown Hospital	Quakertown			✓	✓					
St. Joseph Regional Health Network	Reading	✓	✓	✓	✓					
UPMC Northwest	Seneca	✓		✓	✓					
Roxbury Treatment Center	Shippensburg								✓	
Tyler Memorial Hospital	Tunkhannock			✓						
Williamsport Regional Medical Center	Williamsport	✓	✓	✓	✓			✓		
Main Line Hospitals, Inc.	Wynnewood	✓	✓	✓	✓					
OSS Orthopaedic Hospital	York				✓					
Puerto Rico										
Doctors' Center Hospital Manati	Manati	✓	✓	✓	✓					
Ashford Presbyterian Community Hospital	San Juan	✓			✓					

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Hospitals by State	City	Heart Attack	Heart Failure	Pneumonia	Surgical Care	Children's Asthma	VTE	Stroke	Hosp-Based Inpt Psych	Immun-ization
Rhode Island										
Memorial Hospital of Rhode Island	Pawtucket	✓	✓	✓	✓					
Emma Pendleton Bradley Hospital	Riverside								✓	
South County Hospital Healthcare System	Wakefield	✓		✓	✓					
South Carolina										
Patrick B. Harris Psychiatric Hospital	Anderson								✓	
Marlboro Park Hospital	Bennettsville			✓						
Bon Secours St. Francis Xavier Hospital, Inc.	Charleston		✓	✓						
Roper Hospital, Inc.	Charleston	✓	✓	✓						
Trident Health System	Charleston	✓	✓	✓	✓					
William Jennings Bryan Dorn VA Medical Center	Columbia		✓	✓	✓					
Baptist Easley Hospital	Easley	✓	✓	✓	✓					
Carolinas Hospital System	Florence	✓	✓	✓	✓					
Greenville Hospital System University Medical Center	Greenville	✓	✓	✓						
Patewood Memorial Hospital	Greenville				✓					
Greer Memorial Hospital	Greer			✓						
UHS of Greenville, LLC	Greer								✓	
Coastal Carolina Medical Center, Inc.	Hardeeville			✓	✓					
Springs Memorial Hospital	Lancaster		✓	✓	✓					
East Cooper Medical Center	Mount Pleasant			✓	✓					
Grand Strand Regional Medical Center, LLC	Myrtle Beach	✓	✓	✓	✓					
Newberry County Memorial Hospital	Newberry			✓	✓					
Hillcrest Memorial Hospital	Simpsonville			✓						
Colleton Medical Center	Walterboro		✓	✓	✓					
Three Rivers Behavioral Health, LLC	West Columbia								✓	
South Dakota										
Avera Queen of Peace	Mitchell			✓	✓					
Tennessee										
Western Mental Health Institute	Bolivar								✓	
Wellmont Bristol Regional Medical Center	Bristol	✓	✓	✓	✓					
Parkridge Medical Center, Inc.	Chattanooga	✓	✓	✓	✓				✓	
Clarksville Health System, GP	Clarksville	✓	✓	✓	✓					
Maury Regional Medical Center	Columbia	✓	✓	✓						
TriStar Horizon Medical Center	Dickson	✓	✓	✓	✓					
Dyersburg Hospital Corporation	Dyersburg	✓	✓	✓	✓					
Sumner Regional Medical Center	Gallatin	✓	✓	✓	✓					
TriStar Hendersonville Medical Center	Hendersonville	✓	✓	✓	✓					
TriStar Summit Medical Center	Hermitage	✓	✓	✓	✓					
Baptist Memorial Hospital Huntingdon	Huntingdon			✓						
Jackson, Tennessee Hospital Company, LLC	Jackson	✓	✓	✓	✓					
Jamestown Regional Medical Center	Jamestown			✓						
Franklin Woods Community Hospital	Johnson City			✓	✓					
Fort Sanders Regional Medical Center	Knoxville	✓	✓	✓	✓					
Fort Loudoun Medical Center	Lenoir City			✓	✓					
Lexington Hospital Corporation	Lexington			✓						
McKenzie Tennessee Hospital Company, LLC	McKenzie			✓	✓					
AMISUB (SFH), Inc	Memphis	✓	✓	✓	✓					
Baptist Memorial Hospital	Memphis	✓	✓	✓						
Lakeside Behavioral Health System, LLC	Memphis								✓	
Morristown-Hamblen Hospital Association	Morristown	✓	✓	✓	✓					
James H. Quillen VA Medical Center	Mountain Home	✓	✓	✓	✓					
Middle Tennessee Mental Health Institute	Nashville								✓	
Southern Hills Medical Center	Nashville	✓	✓	✓	✓					
Tennova Newport Medical Center	Newport			✓						
Henry County Medical Center	Paris			✓	✓					
Shelbyville Hospital Corporation	Shelbyville			✓	✓					
DeKalb Community Hospital	Smithville			✓	✓					

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StoneCrest Medical Center	Smyrna	✓	✓	✓	✓					
NorthCrest Medical Center	Springfield	✓	✓	✓	✓					
Baptist Memorial Hospital-Union City	Union City			✓	✓					
Texas										
Big Bend Regional Medical Center	Alpine			✓						
Baylor Orthopedic and Spine Hospital at Arlington	Arlington				✓					
Medical Center Arlington	Arlington	✓	✓	✓	✓					
Millwood Hospital, LP	Arlington								✓	
Sundance Hospital	Arlington								✓	
Texas Health Heart & Vascular Hospital Arlington	Arlington	✓	✓		✓					
Austin State Hospital	Austin								✓	
Dell Children's Medical Center of Central Texas	Austin					✓				
Neuro Institute of Austin, LP	Austin								✓	
Seton Medical Center Austin	Austin	✓	✓	✓	✓					
Seton Southwest Hospital	Austin				✓					
St. David's Medical Center	Austin	✓	✓	✓	✓					
St. David's North Austin Medical Center	Austin	✓	✓	✓	✓					
St. David's South Austin Medical Center	Austin	✓	✓	✓	✓					
Texas Health Harris Methodist Hospital Azle	Azle			✓	✓					
Texas Health HEB Hospital	Bedford	✓	✓	✓	✓			✓	✓	
Scott & White Hospital Brenham	Brenham				✓					
Valley Regional Medical Center	Brownsville	✓	✓	✓	✓					
Brownwood Regional Medical Center	Brownwood			✓	✓					
Baylor Medical Center at Carrollton	Carrollton	✓	✓	✓	✓					
Cedar Park Regional Medical Center	Cedar Park			✓	✓					
Aspire Hospital, LLC	Conroe								✓	
Conroe Regional Medical Center	Conroe	✓	✓	✓	✓					
Montgomery County Mental Health Treatment Facility	Conroe								✓	
Corpus Christi Medical Center (Bay Area Healthcare Group, LTD)	Corpus Christi	✓	✓	✓	✓					
Baylor Heart and Vascular Center, LLP	Dallas	✓	✓		✓					
Baylor Medical Center at Uptown	Dallas				✓					
Baylor University Medical Center (BUMC)	Dallas	✓	✓	✓	✓					
Medical City Dallas Hospital	Dallas	✓	✓	✓	✓					
Methodist Charlton Medical Center	Dallas	✓	✓	✓				✓		
Methodist Dallas Medical Center	Dallas	✓	✓	✓				✓		
North Central Surgical Center	Dallas				✓					
UHS of Timberlawn	Dallas								✓	
UT Southwestern University Hospital	Dallas	✓	✓	✓	✓					
UT Southwestern Zale Lipshy Hospital	Dallas				✓					
Texoma Medical Center	Denison	✓	✓	✓	✓					
Denton Regional Medical Center	Denton	✓	✓	✓	✓					
University Behavioral Health of Denton	Denton								✓	
Fort Duncan Regional Medical Center	Eagle Pass		✓	✓	✓					
Las Palmas Del Sol Healthcare	El Paso	✓	✓	✓	✓					
Baylor Surgical Hospital at Fort Worth	Fort Worth				✓					
Plaza Medical Center of Fort Worth	Fort Worth	✓	✓	✓	✓					
Hill Country Memorial Hospital	Fredericksburg			✓	✓					
Centennial Medical Center	Frisco	✓		✓	✓					
Baylor Medical Center at Garland	Garland	✓	✓	✓	✓					
Harlingen Medical Center, LP	Harlingen	✓	✓	✓	✓					
Behavioral Health Management, LLC	Houston								✓	
CHRISTUS St. John Hospital	Houston	✓	✓	✓	✓					
Houston Northwest Medical Center	Houston	✓	✓	✓	✓					
Memorial Hermann Hospital	Houston	✓	✓	✓	✓					
Memorial Hermann Hospital System	Houston	✓	✓	✓	✓					
Methodist Willowbrook Hospital	Houston	✓	✓	✓	✓					

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Texas Orthopedic Hospital, Ltd.	Houston				✓		✓			
TOPS Surgical Specialty Hospital	Houston				✓					
West Houston Medical Center	Houston	✓	✓	✓	✓					
Woman's Hospital, LP	Houston				✓					
Memorial Hermann Northeast Hospital	Humble	✓	✓	✓	✓					
Las Colinas Medical Center	Irving	✓	✓	✓	✓					
Mother Frances Hospital-Jacksonville	Jacksonville			✓						
South Texas Regional Medical Center	Jourdanton			✓	✓					
CHRISTUS St. Catherine Hospital	Katy	✓	✓	✓	✓					
Memorial Hermann Katy Hospital	Katy		✓	✓	✓					
Texas Health Presbyterian Hospital Kaufman	Kaufman			✓	✓			✓		
Kingwood Pines Hospital	Kingwood								✓	
Memorial Hermann Specialty Hospital Kingwood, LLC	Kingwood				✓					
Laredo Texas Hospital Company, LP	Laredo	✓	✓	✓	✓					
Medical Center of Lewisville	Lewisville	✓	✓	✓	✓					
Covenant Children's Hospital	Lubbock					✓				
Woodland Heights Medical Center	Lufkin	✓	✓	✓	✓					
Seton Edgar B. Davis Hospital	Luling			✓						
Methodist Mansfield Medical Center	Mansfield	✓	✓	✓				✓		
Rio Grande Regional Hospital	McAllen	✓	✓	✓	✓					
BCA of the Permian Basin	Midland								✓	
North Hills Hospital Subsidiary, LP	North Richland Hills	✓	✓	✓	✓					
Baylor Regional Medical Center at Plano	Plano			✓	✓					
THE HEART HOSPITAL Baylor Plano	Plano	✓	✓		✓					
Methodist Richardson Medical Center	Richardson	✓	✓	✓	✓					
Texas Health Presbyterian Hospital Rockwall	Rockwall			✓	✓					
St. David's Round Rock Medical Center	Round Rock	✓	✓	✓	✓					
Lake Pointe Medical Center	Rowlett	✓	✓	✓	✓					
Rusk State Hospital	Rusk								✓	
San Angelo Community Medical Center	San Angelo	✓	✓	✓	✓					
Shannon Medical Center	San Angelo	✓	✓	✓	✓					
Methodist Hospital	San Antonio	✓	✓	✓	✓	✓				
Methodist Stone Oak Hospital	San Antonio	✓	✓	✓	✓					
Nix Health Care System	San Antonio			✓	✓					
South Texas Veterans Health Care System	San Antonio	✓	✓	✓	✓					
Texas Laurel Ridge Hospital, LP	San Antonio								✓	
Central Texas Medical Center	San Marcos			✓	✓					
Memorial Hermann Sugar Land Surgical Hospital	Sugar Land				✓					
Terrell State Hospital	Terrell								✓	
Trophy Club Medical Center	Trophy Club				✓					
DeTar Healthcare System	Victoria	✓	✓	✓	✓					
Weatherford Regional Medical Center	Weatherford			✓	✓					
Clear Lake Regional Medical Center	Webster	✓	✓	✓	✓					
Haven Red River Hospital, LLC	Wichita Falls								✓	
Kell West Regional Hospital, LLC	Wichita Falls				✓					
Utah										
IHC Health Services, Inc.	Cedar City			✓	✓					
Logan Regional Hospital	Logan			✓	✓					
Intermountain Medical Center	Murray	✓	✓		✓					
The Orthopedic Specialty Hospital	Murray				✓					
McKay-Dee Hospital Center	Ogden	✓	✓	✓	✓					
Ogden Regional Medical Center	Ogden	✓		✓	✓					
Mountain View Hospital	Payson	✓		✓	✓					
Utah State Hospital	Provo								✓	
Riverton Hospital	Riverton			✓	✓					
Primary Children's Medical Center	Salt Lake City					✓				
St. Mark's Hospital	Salt Lake City	✓	✓	✓	✓					

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Alta View Hospital	Sandy			✓	✓					
Vermont										
Central Vermont Medical Center	Berlin			✓	✓					
Northwestern Medical Center, Inc.	Saint Albans			✓						
VA Medical Center	White River Junction			✓	✓					
Virginia										
Inova Mount Vernon Hospital	Alexandria		✓	✓	✓					
Virginia Hospital Center	Arlington	✓	✓	✓	✓					
LewisGale Hospital Montgomery	Blacksburg	✓		✓	✓					
Catawba Hospital	Catawba								✓	
Southern Virginia Mental Health Institute	Danville								✓	
Emporia Hospital Corporation	Emporia	✓	✓	✓	✓					
Inova Fair Oaks Hospital	Fairfax	✓	✓	✓	✓					
Spotsylvania Regional Medical Center	Fredericksburg	✓	✓	✓	✓					
Warren Memorial Hospital	Front Royal			✓	✓					
Riverside Walter Reed Hospital	Gloucester	✓	✓	✓	✓					
Riverside Behavioral Health Center	Hampton								✓	
VA Medical Center-Hampton	Hampton				✓					
John Randolph Medical Center	Hopewell	✓	✓	✓	✓					
LewisGale Hospital Alleghany	Low Moor			✓	✓					
Bon Secours Memorial Regional Medical Center	Mechanicsville	✓	✓	✓	✓					
Riverside Regional Medical Center	Newport News	✓	✓	✓	✓					
Central State Hospital	Petersburg								✓	
Reston Hospital Center, LLC	Reston	✓	✓	✓	✓					
Bon Secours-St. Mary's Hospital	Richmond	✓	✓	✓	✓					
CJW Medical Center	Richmond	✓	✓	✓	✓					
Henrico Doctors' Hospital	Richmond	✓	✓	✓	✓					
LewisGale Medical Center, LLC	Salem	✓	✓	✓	✓					
Community Memorial Healthcenter	South Hill			✓				✓		
Riverside Tappahannock Hospital	Tappahannock		✓	✓	✓					
Virginia Beach Psychiatric Center	Virginia Beach								✓	
Eastern State Hospital	Williamsburg								✓	
Washington										
Overlake Health Care Association	Bellevue	✓	✓	✓	✓					
Harrison Medical Center	Bremerton	✓	✓	✓	✓					
Kennewick Public Hospital District	Kennewick		✓	✓	✓					
Harborview Medical Center	Seattle	✓	✓	✓	✓					
Swedish Medical Center	Seattle		✓	✓	✓					
University of Washington Medical Center	Seattle	✓	✓	✓	✓					
VA Medical Center	Spokane			✓						
Legacy Salmon Creek Hospital	Vancouver	✓	✓	✓	✓					
Providence St. Mary Medical Center	Walla Walla			✓	✓					
Central Washington Health Services Association	Wenatchee	✓	✓	✓	✓					
West Virginia										
VA Medical Center-Louis A. Johnson	Clarksburg			✓						
Fairmont General Hospital, Inc.	Fairmont	✓		✓	✓					
Cabell Huntington Hospital, Inc.	Huntington	✓	✓	✓	✓					
River Park Hospital	Huntington								✓	
VA Medical Center	Huntington		✓	✓	✓					
VA Medical Center	Martinsburg		✓	✓	✓					
Wetzel County Hospital	New Martinsville			✓						
Oak Hill Hospital Corporation	Oak Hill			✓	✓					
Pleasant Valley Hospital	Point Pleasant			✓	✓					
The Charles Town General Hospital	Ranson			✓	✓					
Stonewall Jackson Memorial Hospital Company	Weston			✓	✓					
Williamson Memorial Hospital	Williamson			✓	✓					

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Wisconsin										
Affinity Health System-St. Elizabeth Hospital	Appleton	✓		✓	✓					
St. Clare Hospital	Baraboo			✓	✓					
Black River Memorial Hospital, Inc.	Black River Falls			✓	✓					
Aurora Health Care Southern Lakes, Inc.	Burlington			✓	✓					
Mayo Clinic Health System-Eau Claire Hospital, Inc.	Eau Claire	✓		✓	✓			✓		
Aurora Health Care Southern Lakes, Inc.	Elkhorn			✓	✓					
Aurora Medical Center Grafton, LLC	Grafton	✓		✓	✓					
Aurora BayCare Medical Center	Green Bay	✓		✓	✓					
Aurora Medical Center of Washington County	Hartford			✓	✓					
Hudson Hospital & Clinics	Hudson				✓					
Aurora Medical Center Kenosha	Kenosha		✓	✓	✓					
Mayo Clinic Health System-Franciscan Medical Center, Inc.	La Crosse	✓		✓	✓					
Mendota Mental Health Institute	Madison								✓	
William S. Middleton Memorial Veterans Hospital	Madison	✓	✓	✓	✓					
Community Memorial Hospital of Menomonee Falls, Inc.	Menomonee Falls	✓	✓	✓	✓					
Good Samaritan Health Center of Merrill, Wisconsin, Inc.	Merrill				✓		✓			
Aurora Health Care Metro, Inc.	Milwaukee	✓	✓	✓	✓					
Clement J. Zablocki VA Medical Center	Milwaukee	✓	✓	✓	✓					
Froedtert Memorial Lutheran Hospital	Milwaukee	✓	✓	✓	✓					
Aurora Health Care Southern Lakes, Inc.	Oconomowoc	✓		✓	✓					
Aurora Medical Center of Oshkosh	Oshkosh	✓		✓	✓					
Mercy Medical Center	Oshkosh	✓		✓	✓					
Prairie du Chien Memorial Hospital Association, Inc.	Prairie du Chien			✓	✓					
Wheaton Franciscan Healthcare-All Saints, Inc.	Racine	✓	✓	✓	✓					
Lakeview Medical Center	Rice Lake			✓	✓					
River Falls Area Hospital	River Falls				✓					
Aurora Health Care Central, Inc.	Sheboygan	✓		✓	✓					
St. Nicholas Hospital	Sheboygan			✓	✓					
Stoughton Hospital	Stoughton			✓	✓					
Aurora Health Care North, Inc.	Two Rivers			✓	✓					
Waupun Memorial Hospital	Waupun			✓	✓					
Wyoming										
Wyoming Medical Center	Casper	✓	✓	✓	✓					
St. John's Medical Center	Jackson			✓	✓		✓			
Riverton Memorial Hospital	Riverton			✓	✓					
Department of Defense International Locations										
United Kingdom										
48th Medical Group RAF Lakenheath	Brandon, Suffolk						✓			

EXHIBIT 38 – CHARITY AND BAD DEBT POLICIES

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

TITLE: **Financial Assistance / Charity Care** **Policy: 500**

TOPIC

Financial Assistance / Charity Care

ECHN is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate those who are poor and disenfranchised, ECHN strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

PURPOSE

To identify those patients that qualify for charitable assistance and to complete write-off procedures that are in keeping with state and federal regulations.

A. ECHN is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
B. It is the policy of ECHN to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy is to describe how applications for Federal Assistance should be made, the criteria for eligibility, and the steps for processing each application.
C. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financials Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.
D. Race, gender, sexual orientation, religious or political affiliation, social or immigration status will not be taken into consideration.
E. To further ECHN's commitment to their mission to provide healthcare to patients seeking emergency care, ECHN will utilize an abbreviated application for financial assistance for their uninsured patients being seen in the Emergency Room. The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage.

POLICY:

In order to provide the level of aid necessary to the greatest number of patients in need, and protect the resources needed to do so, the following guidelines apply:

A. Patient
    a. Services are provided under charity care only when deemed medically necessary and after patients are found to have met all financial criteria based on the disclosure of proper information and documentation.
    b. Any patient who believes that they are qualified may apply for financial assistance under the hospitals' charity care policy or discount policy.
    c. Patients are expected to contribute payment for care based on their individual financial situation; therefore, each case will be reviewed separately.
    d. Charity Care is not considered an alternative option to payment and patients may be assisted in finding other means of payment or financial assistance before approval for charity care.

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

e. Uninsured patients who are believed to have the financial ability to purchase health insurance may be encourage to do so in order to ensure healthcare accessibility and overall well-being.

B. Hospital
   a. ECHN will maintain an understandable, written financial assistance policy, clearly stating the eligibility criteria.
   b. ECHN will ensure that all financial assistance policies will be applied consistently.
   c. In applying the Financial Assistance policy, ECHN will assist the patent in determining if he/she is eligible for government- sponsored programs.

C. COMMUNICATION:
   a. Notices regarding availability of Charity Care at ECHN will be posted in public places around the hospital, on patient bills, and on our website.

PROCEDURE

a. Services Eligible Under This Policy
   i. The following healthcare services are eligible for charity:
      1. Emergency medical services provided in an emergency room setting;
      2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
      3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
      4. Medically necessary services, evaluated on a case-by-case basis at ECHN's discretion.

b. Eligibility for Charity Care
   1. Eligibility for Charity Care will be based on an individuals assessment of financial need.
   2. Requires an application process.
   3. We expect cooperation from patients and guardians.
   4. May rely upon publicly available information and resources to determine the financial resources of the patient or a potential guardian.
   5. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
   6. The need for financial assistance shall be re-evaluated every six months or at any time additional information relevant to the eligibility of the patient for charity care becomes known.

c. Presumptive Financial Assistance Eligibility
   i. There are instances when a patient may appear eligible for charity care discounts, but are unable to provide supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance such as
      1. State-funded prescription programs;
      2. Patient is homeless or received care from a homeless clinic;
      3. Patient files bankruptcy
      4. Participation in Women, Infants and Children programs (WIC);
      5. Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act
      6. Food stamp eligibility;
      7. Subsidized school lunch program eligibility;
      8. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
      9. Low income/subsidized housing is provided as a valid address; and
      10. Patient is deceased with no known estate.

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

D. ASSESSMENT PROCESS

1. The application must be fully completed and signed by the patient / responsible party
2. Proof of income for applicant (and spouse if applicable) is verified by two forms of documentation which could include:
    a. Last four pay stubs
    b. Previous Year Federal Income Tax Form
    c. Previous Year W-2 Form
    d. Social Security Statement
    e. Unemployment Benefit Statement
3. Other documentation that may be required:
    a. Proof of disability compensation
    b. For Medicare patients a copy of their social security benefits, pension and retirement benefits and/or bank statements showing deposits
    c. Workers compensation deposits

i. The level of Charity Care provided will be determined based on the Federal Poverty Level in effect (please refer to the current year's sliding scale).

ii. Once a patient has been granted financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

E. PRESUMPTIVE PRACTICES FOR CHARITY CARE PATIENTS

a. Internal and external collection policies and procedures will take into account the extent to which a patient is qualified for charity care or discounts. In additional, patients who qualify for partial discounts are required to make a good faith effort to honor payment agreements with ECHN, including payment plans and discounted hospital bills. ECHN is committed to working with patients to resolve their accounts, and at its discretion, may provide extended payment plans to eligible patients. ECHN will not pursue legal action for non-payment of bills against charity care patients who have cooperated with the hospital to resolve their accounts and have demonstrated their income and/or assets are insufficient to pay medical bills.

b. During the eligibility process, other forms of financial assistance will be considered such as Medicare and Medicaid.

DEFINITIONS

The following terms are meant within this policy to be interpreted as follows:

a. Charity Care means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in the hospital's charity care policies on file at OCHA.

b. Emergency Care: Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any organs or parts.

c. Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal revenue Services rules, if the patient claims someone as a dependant on their income tax return, they may be considered a dependent for purposed of the provision of financial assistance.

d. Family Income: family income is determined using the census Bureau definition, which uses the following income when computing federal poverty guidelines.
    i. Includes earnings, unemployment compensation, workers' compensation, Social security, Supplemental security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income form estates, trusts, educational assistance, alimony, child support, assistance form outside the household, and other miscellaneous sources.
    ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
    iii. Determined on a before-tax basis
    iv. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates do not count)

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

e. Medically Necessary: hospital services or care rendered (both inpatient and outpatient) to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
f. Presumptive: other financial assistance, not charity care.
g. Underinsured: Patients who carry insurance of have third party assistance to help pay for medical services, but who accrue or have the likelihood of accruing out-of-pocket expenses which exceed their financial ability.
h. Uninsured: means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified an uninsured patient, is such subsequent reimbursement takes place.
i. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 hours.

ATTACHMENTS: A

INDIVIDUAL RESPONSIBLE FOR REVISION: Director Patient Financial Services

ORIGINATED: 07/29/02 REVISION DATE: 8/1/05
8/3/07
9/20/10
11/26/12
04/15/13

Notice of Availability for Uncompensated Care

Eastern Connecticut Health Network, Inc. will provide assistance for those patients who fall within the guidelines below.

To be eligible to receive uncompensated care, your family must be at or below the following current guidelines.

2014 POVERTY GUIDELINES

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE 100%	120%	133%	135%	150%	175%	185%	200%	250%
1	11,670.00	14,004.00	15,521.10	15,754.50	17,505.00	20,422.50	21,589.50	23,340.00	29,175.00
2	15,730.00	18,876.00	20,920.90	21,235.50	23,595.00	27,527.50	29,100.50	31,460.00	39,325.00
3	19,790.00	23,748.00	26,320.70	26,716.50	29,685.00	34,632.50	36,611.50	39,580.00	49,475.00
4	23,850.00	28,620.00	31,720.50	32,197.50	35,775.00	41,737.50	44,122.50	47,700.00	59,625.00
5	27,910.00	33,492.00	37,120.30	37,678.50	41,865.00	48,842.50	51,633.50	55,820.00	69,775.00
6	31,970.00	38,364.00	42,520.10	43,159.50	47,955.00	55,947.50	59,144.50	63,940.00	79,925.00
7	36,030.00	43,236.00	47,919.90	48,640.50	54,045.00	63,052.50	66,655.50	72,060.00	90,075.00
8	40,090.00	48,108.00	53,319.70	54,121.50	60,135.00	70,157.50	74,166.50	80,180.00	100,225.00

For family units of more than 8 members, add $4,060 for each additional member.
Produced by: CMCS/CAHPG/DEEO

If you feel you may be eligible, you may request free or discounted services at the Patient Financial Service Office. Requests may be made prior to admission, during the stay or at time of discharge. A financial evaluation form and application will be provided for the applicant upon request. The Hospital will make a final determination of your eligibility for uncompensated services.

When Third Party coverage is available (Medicare, State, Medicaid LIA, etc) all applicable benefits must be applied first. Patient convenience items such as private room differentials are not covered.

Refusal to take reasonable actions necessary to obtain these available benefits can exclude the granting of uncompensated services.

Source – Federal Register Income Poverty Guidelines

PATIENT FINANCIAL SERVICES
POLICIES AND PROCEDURES

ECHN
Eastern Connecticut Health Network, Inc.

SUBJECT: **Pre-Collect and Bad Debt Policy** **POLICY NO: 4005**
SECTION: **PAGE**

I. TITLE: Departmental Pre-Collect and Bad Debt Policy and Procedures

II. POLICY: This policy applies to the Manchester Memorial and Rockville General Hospitals Patient Financial Services

III. PURPOSE: To ensure that bad debt accounts are appropriately identified and consistently processed within the guidelines of the hospital's credit and collection policy.

IV. RESPONSIBILITES:

A. To ensure that accounts with outstanding patient balances beyond 120 days are written off to bad debt. Accounts are considered bad debt once reviewed by the Self Pay Team and the Pre-Collections Unit as uncollectible. It must be determined that the accounts meet the following criteria:
   a. The account has aged 120 days from the date the balance became the responsibility of the patient / guarantor without payment in full.
   b. No reasonable response from the patient in the previous 120 days.
   c. Guarantor has received at least four statements.
   d. Third party carrier has denied in writing the responsibility for any payment (partial or full) towards the account and the collector has documented the patient / guarantor's refusal for payment or financing when applicable.
   e. Guarantor has defaulted on an "agree to payment plan" (for two consecutive months or more)
   f. The account has been flagged as a "bad address" or "mail return".

B. If the above criteria has been met, and at the 4th statement, the account is transferred to the pre-collection list for potential bad debt and is designated to be analyzed for the month end bad debt / write off function. Steps to occur are:
   a. On the 25th of the month
      i. Run is run to capture all accounts set to receive 4 statements from the 25th thru the 24th of the next month.
      ii. Individually review each account to determine if meets criteria for pre-collect letter
         1. Guarantor has received at least 4 statements
         2. Account not paid in full
         3. defaulted on pay plan
            A. PFS will ensure that the guarantor has been notified in writing that they are in default and in danger of going to collection, after first missed month.
         4. Identified as return mail. Researched, collector changed, and 2 months noted on account.
         5. "Dirty buckets" (money in insurance and self pay) need to be resolved prior to pre-collect letter.
         6. The total pre-collect dollars can not exceed the established bad debt turnover number.
         7. Only one pre-collect letter will go out on each account.
         8. Identify accounts that are not eligible for write off-due to established criteria, Medicaid eligibility, bankruptcy, or the patient is deceased.
         9. Document in financial comments the reason that any account is not eligible for bad debt write off.

b. Once the monthly pre-collect accounts have been identified and worked, change the self pay collector for the pre-collect code designated for that month and year .
c. On the fourth day of the month
    i. Finalize pre-collect review
        1. Produce and send out pre-collect letters.
            A. Ensuring that the total dollars do not exceed the bad debt turnover number
            B. No account has been previously send a pre-collect letter
        2. Retain copy of pre-collect report for our records.
d. By the 3rd Friday of the month
    i. Review pre-collect accounts for payments
    ii. Review pre-collect accounts for Medicaid Eligibility
    iii. Request bad debt write off according to the following monetary guidelines:
        1. Balance of between $20 and $999 - no approval necessary
        2. Balances between $1,000 and $3,900 – reviewed by Non Governmental Specialist
        3. Balances between $4,000 and $9,999 – reviewed and approved by Non Gov Manager
        4. Balances greater than $10,000- reviewed and approved by Department Manager
    iv. Report bad debt turnover number to management
e. On the twenty fifth of the month
    i. Review pre-collect accounts for payments
    ii. Review pre-collect accounts for Medicaid Eligibility
    iii. Received appropriate approval from management according to established monetary guidelines, which are retained for our records.
    iv. Review reports to agree with final dollar amount and account age prior to account transfer
    v. Electronically transfer the selected accounts to bad debt status
f. On the last day of the month
    i. Ensure that the self pay payments have been posted for the month
    ii. Review bad debt accounts for payments
    iii. Review bad debt accounts for Medicaid Eligibility
    iv. Report final month end Bad Debt totals to management
g. On the third business day after conclusion of month end process
    i. Final review of bad debt accounts for payments
    ii. Final review of bad debt accounts for Medicaid Eligibility
    iii. Transmit electronic file to collection agency
    iv. Run bad debt report and retain copy of our records

C. It is essential that in conjunction with the bad debt process, that the following areas also need to be kept current and worked daily
    a. Bankruptcies to be worked daily
    b. Charity Care to be worked daily

VII. INDIVIDUAL RESPONSIBLE FOR REVISION: Director, PFS

VIII. ORIGINATED: 11/04 REVISION DATE: 12/13
11/09

EXHIBIT 39 –OHCA FINANCIAL STATISTICS REPORTS

Monthly Financial Statistics for August 2014, August 2014 Year-To-Date and Comparison to the Prior Year

	Rockville General Hospital				Manchester Memorial Hospital				Eastern CT Health Network			
	Current August-14	Prior Year August-13	Current YTD August 2014	Prior Year YTD August 2013	Current August-14	Prior Year August-13	Current YTD August 2014	Prior Year YTD August 2013	Current August-14	Prior Year August-13	Current YTD August 2014	Prior Year YTD August 2013
A. Operating Performance												
Operating Margin	-0.70%	9.89%	0.90%	5.75%	5.93%	-1.62%	3.49%	0.69%	0.97%	-1.48%	0.03%	0.11%
Non-Operating Margin	-0.17%	0.45%	-0.43%	-0.58%	-0.40%	-0.21%	-0.84%	-0.74%	-0.27%	0.94%	-0.56%	-0.45%
Total Margin	-0.87%	10.34%	0.47%	5.17%	5.53%	-1.83%	2.65%	-0.05%	0.69%	-0.54%	-0.53%	-0.34%
Bad Debt as % of Gross Revenue	0.84%	1.63%	0.65%	1.68%	0.66%	0.96%	0.66%	1.10%	0.79%	1.26%	0.75%	1.32%
B. Liquidity												
Current Ratio	1.69	1.70	1.69	1.70	1.19	1.55	1.19	1.55	1.38	1.50	1.38	1.50
Days Cash on Hand	73	81	70	73	30	32	29	31	66	62	64	59
Days in Net Accounts Receivable	60	62	57	59	64	83	60	73	55	60	53	55
Average Payment Period	44	48	42	43	61	50	60	48	58	58	57	55
C. Leverage and Capital Structure												
Long-term Debt to Equity	0.8	1.0	0.8	1.0	1.7	5.0	1.7	5.0	1.0	1.7	1.0	1.7
Long-term Debt to Capitalization	0.4	0.5	0.4	0.5	0.6	0.8	0.6	0.8	0.5	0.6	0.5	0.6
Unrestricted Cash to Debt	0.6	0.6	0.6	0.6	0.3	0.3	0.3	0.3	0.7	0.6	0.7	0.6
Times Interest Earned Ratio	(0.9)	17.4	5.8	12.2	2.9	2.3	18.2	3.8	5.2	3.5	3.3	4.0
Debt Service Coverage Ratio	3.7	12.5	2.7	4.1	2.4	0.4	2.3	0.7	1.6	0.2	1.3*	1.3*
Equity Financing Ratio	0.4	0.3	0.4	0.3	0.2	0.1	0.2	0.1	0.3	0.2	0.3	0.2
D. Additional Statistics												
Income from Operations	$ (40,468)	$ 593,498	$ 597,288	$ 3,964,674	$ 968,069	$ (241,374)	$ 6,047,917	$ 1,187,991	$275,448	($404,791)	$96,481	$331,646
Revenue Over/(Under) Expense	$ (50,522)	$ 620,378	$ 312,476	$ 3,565,501	$ 902,873	$ (272,016)	$ 4,598,864	$ (84,648)	$197,211	($148,132)	($1,634,590)	($1,063,995)
EBITDA	$ 297,661	$ 948,756	$ 4,025,552	$ 7,690,454	$ 1,751,293	$ 2,691,642	$ 11,389,201	$ 9,465,652	$1,583,452	$1,170,091	$13,135,159	$14,591,265
Patient Cash Collected	$ 5,677,456	$ 6,204,021	$ 65,630,060	$ 64,114,566	$ 14,385,381	$ 14,689,149	$ 160,999,481	$ 153,483,829	$ 24,357,786	$ 23,759,550	$ 277,580,118	$ 232,156,993
Cash and Cash Equivalents	$ 13,173,266	$ 13,396,543	$ 13,173,266	$ 13,396,543	$ 14,273,371	$ 15,138,736	$ 14,273,371	$ 15,138,736	$57,927,060	$52,867,155	$57,927,060	$52,867,155
Net Working Capital	$ 5,397,747	$ 5,522,071	$ 5,397,747	$ 5,522,071	$ 5,550,496	$ 12,985,211	$ 5,550,496	$ 12,985,211	$ 19,611,712	$ 24,455,540	$ 19,611,712	$ 24,455,540
Unrestricted Assets	$ 26,051,748	$ 19,037,078	$ 26,051,748	$ 19,037,078	$ 18,971,156	$ 408,035	$ 18,971,156	$ 408,035	$ 69,653,116	$ 35,482,350	$ 69,653,116	$ 35,482,350
Credit Ratings (Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*ECHN YTD FIGURE IS FROM INTERNAL CALC

EXHIBIT 40 – IRS TAX FORM 990 FILED BY MMH AND RGH FOR TAX YEAR 2013

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 5.x products, uncheck the "Shrink oversized pages to paper size" and uncheck the "Expand small pages to paper size" options, in the Adobe "Print" dialog. When using Acrobat 6.x and later products versions, select "None" in the "Page Scaling" selection box in the Adobe "Print" dialog.

CLIENT'S COPY

UNRELATED BUSINESS INCOME

CARRYOVER DATA TO 2013

Name	Employer Identification Number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	728,020.
FEDERAL AMT NET OPERATING LOSS	728,020.
CT CURRENT YEAR NET OPERATING LOSS	112,441.

219341
10-23-12

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 15, 2014.

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2012

Open to Public Inspection

A For the 2012 calendar year, or tax year beginning OCT 1, 2012 and ending SEP 30, 2013

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
MANCHESTER MEMORIAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
71 HAYNES STREET

City, town, or post office, state, and ZIP code
MANCHESTER, CT 06040

F Name and address of principal officer: PETER J. KARL
SAME AS C ABOVE

D Employer identification number
06-0646710

E Telephone number
860-646-1222

G Gross receipts $ 189,359,036.

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ECHN.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1920

M State of legal domicile: CT

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES, INCLUDING	
	2	Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3	Number of voting members of the governing body (Part VI, line 1a)	18
	4	Number of independent voting members of the governing body (Part VI, line 1b)	12
	5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	1856
	6	Total number of volunteers (estimate if necessary)	449
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	910,987.
	b	Net unrelated business taxable income from Form 990-T, line 34	-112,441.

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	4,217,696.	3,158,530.
	9	Program service revenue (Part VIII, line 2g)	188,389,725.	181,137,247.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	671,876.	2,801,853.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	855,718.	913,163.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	194,135,015.	188,010,793.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	24,438.	14,650.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	106,417,075.	111,568,140.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	77,776,479.	77,341,310.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	184,217,992.	188,924,100.
	19	Revenue less expenses. Subtract line 18 from line 12	9,917,023.	-913,307.

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	170,071,385.	174,154,774.
	21	Total liabilities (Part X, line 26)	155,065,612.	136,423,034.
	22	Net assets or fund balances. Subtract line 21 from line 20	15,005,773.	37,731,740.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ MICHAEL D. VEILLETTE, CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
BETH A. THURZ	BETH A. THURZ	08/14/14		P00346435

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP — Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 — Phone no. 860-678-9200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III X

1 Briefly describe the organization's mission:
MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 24,171,729. including grants of $) (Revenue $ 16,528,114.)
INPATIENT SERVICES - MANCHESTER MEMORIAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 249 BED ACCUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 9,342 INPATIENTS TREATED IN FISCAL YEAR 2013. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses $ 16,269,406. including grants of $) (Revenue $ 29,448,252.)
LABORATORY - WE ARE CAP ACCREDITED AND OFFER A WIDE RANGE OF CLINICAL TESTING PROCEDURES USING STATE-OF-THE-ART INSTRUMENTS TO PROVIDE TIMELY, ACCURATE RESULTS. OUR BOARD CERTIFIED PATHOLOGISTS UTILIZE STATE OF THE ART AUTOMATED EQUIPMENT PROVIDING RAPID TURNAROUND TIME, AND INTEGRATION OF TEST RESULTS WITH MEDICAL RECORDS.

4c (Code:) (Expenses $ 15,097,525. including grants of $) (Revenue $ 31,963,077.)
EMERGENCY DEPARTMENT - EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.)
(Expenses $ 92,905,840. including grants of $ 14,650.) (Revenue $ 102,286,817.)

4e **Total program service expenses** ▶ 148,444,500.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	X	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highest compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	349		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		1c	X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1856		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		3a	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*		3b	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a		X
b	If "Yes," enter the name of the foreign country: ▶				
	See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		6a		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		7a		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		8		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?		9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		9b		
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?		13a		
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		14a		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*		14b		

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response to any question in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	18		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ NONE

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

NICHOLAS JAMIESON - 860-646-1222

71 HAYNES STREET, MANCHESTER, CT 06040

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response to any question in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL, M.D.	1.00									
CHAIRMAN	4.00	X		X				0.	0.	0.
(2) ROBIN MURDOCK MEGGERS	1.00									
VICE CHAIR	2.00	X		X				0.	0.	0.
(3) MICHELE CONLON, M.D.	1.00									
SECRETARY	2.00	X		X				0.	0.	0.
(4) GORDON BRODIE, M.D.	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(5) THOMASINA CLEMONS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(6) ANTHONY DISTEFANO, M.D.	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(7) MILTON DOREMUS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(8) JOY DORIN	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(9) LOUISE ENGLAND	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(10) DAVID GONCI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(11) REBECCA JANENDA	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(12) JOSEPH JEAMEL JR.	1.00									
TREASURER	2.00	X		X				0.	0.	0.
(13) CLAUDIO MILITE, M.D.	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(14) LENORA WILLIAMS, M.D.	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(15) PETER J. KARL	37.50									
PRESIDENT AND CEO	5.00	X		X				769,136.	0.	113,819.
(16) DONALD GENOVESI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(17) KATHLEEN A. O'NEILL	1.00									
TRUSTEE	3.00	X						0.	0.	0.

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) KEITH J. WOLF	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(19) KEVIN G. MURPHY	37.50									
EVP, TREASURER	5.00			X				471,431.	0.	66,570.
(20) MICHAEL D. VEILLETTE	37.50									
SVP, CHIEF FINANCIAL OFFICER	5.00			X				355,183.	0.	46,063.
(21) DEBORAH GOGLIETTINO	37.50									
SVP, HUMAN RESOURCES	5.00				X			291,172.	0.	41,750.
(22) DENNIS MCCONVILLE	37.50									
SVP, STRATEGIC PLANNING	5.00				X			261,775.	0.	83,473.
(23) DEBORAH PARKER	37.50									
EVP, CHIEF CLINICAL OFFICER	5.00				X			335,989.	0.	52,120.
(24) JOEL REICH, M.D.	37.50									
SVP, MEDICAL AFFAIRS	5.00				X			400,584.	0.	119,117.
(25) CHARLES COVIN	37.50									
VP AND CIO	5.00				X			214,967.	0.	38,484.
(26) LEONA CROSSKEY	37.50									
VP, QUALITY	5.00				X			172,720.	0.	69,166.
1b **Sub-total** ▶								3,272,957.	0.	630,562.
c **Total from continuation sheets to Part VII, Section A** ▶								2,566,283.	0.	191,547.
d **Total (add lines 1b and 1c)** ▶								5,839,240.	0.	822,109.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 130

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ARUP LABORATORIES, INC. PO BOX 27964, SALT LAKE CITY, UT 84127	LABORATORY SERVICES	1,218,725.
GRIFFIN YORK & KRAUSE 121 RIVER FRONT DRIVE, MANCHESTER, NH 03102	ADVERTISING SERVICES	1,028,914.
FUSS & O'NEILL INC. 146 HARTFORD ROAD, MANCHESTER, CT 06040	ENVIRONMENTAL SERVICES	725,179.
ROBINSON & COLE, 280 TRUMBULL STREET, HARTFORD, CT 06103-3597	LEGAL SERVICES	659,192.
HEALOGICS WOUND CARE & HYPERBARIC 3087 MOMENTUM PLACE, CHICAGO, IL 60689-5330	WOUND SERVICES	608,807.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 41

SEE PART VII, SECTION A CONTINUATION SHEETS

Form 990 MANCHESTER MEMORIAL HOSPITAL 06-0646710

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) ROBERT CARROLL, M.D.	37.50									
MED DIR, EMERGENCY DEPARTMENT	5.00				X			528,665.	0.	28,137.
(28) JAMES A. CASTELLONE,, M.D.	37.50									
ASST. MED DIR, EMERGENCY DEPARTMENT						X		413,212.	0.	9,930.
(29) SCOTT BROWN, M.D.	37.50									
DOCTOR						X		377,584.	0.	29,017.
(30) ANDREAS J. BOJKO, M.D.	37.50									
EMERGENCY DEPT PHYSICIAN						X		391,654.	0.	69,415.
(31) ENOCH DARKO, M.D.	37.50									
EMERGENCY DEPT PHYSICIAN						X		364,576.	0.	9,930.
(32) THEODORE SHERRY, M.D.	37.50									
EMERGENCY DEPT PHYSICIAN						X		370,838.	0.	29,016.
(33) KATHLEEN SIMS	37.50									
FORMER VP, OPERATIONS	5.00						X	119,754.	0.	16,102.
Total to Part VII, Section A, line 1c								2,566,283.		191,547.

Part VIII Statement of Revenue

Check if Schedule O contains a response to any question in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c	324,379.			
	d	Related organizations	1d				
	e	Government grants (contributions)	1e	1,495,315.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	1,338,836.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f		3,158,530.			
Program Service Revenue			Business Code				
	2a	PATIENT SERVICE REVENUE	622110	170,299,621.	170,299,621.		
	b	OTHER HEALTHCARE REVENUE	621500	10,837,626.	9,926,639.	910,987.	
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f		181,137,247.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		709,186.			709,186.
	4	Income from investment of tax-exempt bond proceeds					
	5	Royalties					
			(i) Real / (ii) Personal				
	6a	Gross rents	470,558.				
	b	Less: rental expenses	765,884.				
	c	Rental income or (loss)	-295,326.				
	d	Net rental income or (loss)		-295,326.			-295,326.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	2,092,667.				
	b	Less: cost or other basis and sales expenses	0.				
	c	Gain or (loss)	2,092,667.				
	d	Net gain or (loss)		2,092,667.			2,092,667.
	8a	Gross income from fundraising events (not including $ 324,379. of contributions reported on line 1c). See Part IV, line 18	a 97,038.				
	b	Less: direct expenses	b 219,567.				
	c	Net income or (loss) from fundraising events		-122,529.			-122,529.
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities					
	10a	Gross sales of inventory, less returns and allowances	a 560,368.				
	b	Less: cost of goods sold	b 362,792.				
	c	Net income or (loss) from sales of inventory		197,576.			197,576.
		Miscellaneous Revenue	Business Code				
	11a	CAFETERIA REVENUE	722210	922,309.			922,309.
	b	AUXILIARY REVENUE	900099	211,133.			211,133.
	c						
	d	All other revenue					
	e	**Total.** Add lines 11a-11d		1,133,442.			
	12	**Total revenue.** See instructions.		188,010,793.	180,226,260.	910,987.	3,715,016.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response to any question in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	14,650.	14,650.		
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	2,826,236.		2,826,236.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	81,083,113.	61,623,166.	19,459,947.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,410,829.	4,599,205.	811,624.	
9 Other employee benefits	16,738,439.	14,227,673.	2,510,766.	
10 Payroll taxes	5,509,523.	4,683,095.	826,428.	
11 Fees for services (non-employees):				
a Management	98,029.		98,029.	
b Legal	20,582.		20,582.	
c Accounting	123,450.		123,450.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	10,733,476.	6,440,085.	4,293,391.	
12 Advertising and promotion	94,029.		94,029.	
13 Office expenses	557,986.	278,993.	278,993.	
14 Information technology	311,478.	155,739.	155,739.	
15 Royalties				
16 Occupancy	4,097,518.	3,482,890.	614,628.	
17 Travel	42,669.	36,269.	6,400.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	260,926.	221,787.	39,139.	
20 Interest	2,685,044.	2,685,044.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,115,302.	6,048,007.	1,067,295.	
23 Insurance	5,697,439.	4,842,823.	854,616.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES/EQUIPM	23,422,863.	23,422,863.		
b ECHN ALLOCATION	10,843,139.	6,505,883.	4,337,256.	
c PHYSICIAN FEES	7,962,962.	7,962,962.		
d DUE DILIGENCE	1,302,563.		1,302,563.	
e All other expenses	1,971,855.	1,213,366.	758,489.	
25 **Total functional expenses.** Add lines 1 through 24e	188,924,100.	148,444,500.	40,479,600.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response to any question in this Part X ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	6,414,688.	1	12,239,488.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	26,534,856.	4	27,182,276.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	2,660,785.	8	3,245,125.
	9	Prepaid expenses and deferred charges	2,028,449.	9	2,316,130.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 189,349,328.			
	b	Less: accumulated depreciation — 10b: 134,774,977.	51,317,622.	10c	54,574,351.
	11	Investments - publicly traded securities	18,295,109.	11	14,768,541.
	12	Investments - other securities. See Part IV, line 11	15,193,667.	12	11,580,018.
	13	Investments - program-related. See Part IV, line 11	9,765,167.	13	10,780,266.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	37,861,042.	15	37,468,579.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	170,071,385.	16	174,154,774.
Liabilities	17	Accounts payable and accrued expenses	17,702,182.	17	21,391,578.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	43,201,382.	20	42,014,127.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties	18,870,010.	23	19,189,304.
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	75,292,038.	25	53,828,025.
	26	**Total liabilities.** Add lines 17 through 25	155,065,612.	26	136,423,034.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	4,925,515.	27	27,759,929.
	28	Temporarily restricted net assets	1,905,069.	28	1,392,902.
	29	Permanently restricted net assets	8,175,189.	29	8,578,909.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	15,005,773.	33	37,731,740.
	34	Total liabilities and net assets/fund balances	170,071,385.	34	174,154,774.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	188,010,793.
2	Total expenses (must equal Part IX, column (A), line 25)	2	188,924,100.
3	Revenue less expenses. Subtract line 2 from line 1	3	-913,307.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	15,005,773.
5	Net unrealized gains (losses) on investments	5	470,606.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	23,168,668.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	37,731,740.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☒ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	X	

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I b ☐ Type II c ☐ Type III - Functionally integrated d ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii)	A family member of a person described in (i) above?	11g(ii)	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document? Yes	(iv) No	(v) Did you notify the organization in col. (i) of your support? Yes	(v) No	(vi) Is the organization in col. (i) organized in the U.S.? Yes	(vi) No	(vii) Amount of monetary support
Total									

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) ▶ 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)) ▶ 14 %

15 Public support percentage from 2011 Schedule A, Part II, line 14 ▶ 15 %

16a **33 1/3% support test - 2012.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2011.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2012** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2011** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2011.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Schedule B (Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.

OMB No. 1545-0047

2012

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on Part I, line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	ESTATE OF SYLVAIN E. OFIARA C/O MALCOLM F. BARLOW, ESQ. 172 EAST CENTER STREET MANCHESTER, CT 06040	$ 211,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	ANDREW FERGUSON TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 202,583.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3	AUXILIARY OF MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040	$ 176,165.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4	SBM CHARITABLE FOUNDATION 935 MAIN STREET MANCHESTER, CT 06040	$ 145,476.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
5	RUSSELL G. HARTMANN [redacted]	$ 114,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
6	ESTATE OF LEAH P. BRYAN C/O MURTHA CULLINA 185 ASYLUM STREET, 29TH FLOOR HARTFORD, CT 06103	$ 101,669.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	ANNE L. BEECHLER (ANONYMOUS) [redacted]	$ 101,331.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
8	HARTFORD FOUNDATION FOR PUBLIC GIVING HARTFORD SQUARE NORTH, 10 COLUMBUS BLVD, 8TH FL HARTFORD, CT 06106	$ 93,453.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
9	THE MARY K. BARTON TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 64,303.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
10	TIMKEN FOUNDATION OF CANTON 586 HILLIARD STREET MANCHESTER, CT 06040	$ 55,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
11	ESTATE OF VERONICA C. IRVINE [redacted]	$ 51,885.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
12	COMMUNITY CANCERCARE 100 HAYNES STREET MANCHESTER, CT 06040	$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	MANCHESTER MEMORIAL HOSPITAL VOLUNTEERS 71 HAYNES STREET MANCHESTER, CT 06040	$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
14	WILLIE T. MORTON TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 11,375.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
15	TWIN NETWORKS 8 SCHOOL HILL LANE, SUITE 100 WESTBROOK, CT 06498	$ 11,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
16	SUSAN T. BERTE [redacted]	$ 10,850.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
17	EASTERN CONNECTICUT PATHOLOGY CONSULTANTS, PC 71 HAYNES STREET MANCHESTER, CT 06040-4131	$ 11,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
18	JOSEPHINE T. KRIKORIAN [redacted]	$ 10,350.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	AMBULANCE SERVICE OF MANCHESTER 275 NEW STATE ROAD, P.O. BOX 300 MANCHESTER, CT 06045-0300	$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
20	MANCHESTER ROAD RACE COMMITTEE, INC. PO BOX 211 MANCHESTER, CT 06045-0211	$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
21	MEDICAL ONCOLOGY AND BLOOD DISORDERS, LLP 100 HAYNES STREET MANCHESTER, CT 06040	$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
22	ROCKVILLE BANK FOUNDATION, INC. 1645 ELLINGTON ROAD SOUTH WINDSOR, CT 06074-2764	$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
23	SANTANDER BANK, N.A. 115 ASYLUM STREET, 2ND FLOOR HARTFORD, CT 06103	$ 7,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
24	MAYTIE CASE CROWELL TRUST 185 ASYLUM STREET HARTFORD, CT 06103	$ 6,593.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25	VALERIE F. DEQUATTRO [redacted]	$ 6,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
26	DEBORAH R. GOGLIETTINO 71 HAYNES STREET MANCHESTER, CT 06040	$ 6,350.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
27	VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, INC. 8 KEYNOTE DRIVE VERNON, CT 06066-5040	$ 7,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
28	LUELLA HALE TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 5,682.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
29	DAVID A. CHERRY [redacted]	$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
30	RONALD MCDONALD HOUSE CHARITIES P.O. BOX 226 AGAWAM, MA 01001	$ 5,400.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31	PHILADELPHIA INSURANCE COMPANIES ONE BALA PLAZA, SUITE 100 BALA CYNWYD, PA 19004	$ 5,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
32	JEWELS FOR JONI [redacted]	$ 5,060.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
33	GRACE ROBERTSON TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 5,014.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
34	BUCKLAND HILLS IMAGING 491 BUCKLAND ROAD, SUITE 1 SOUTH WINDSOR, CT 06074	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
35	CONNECTICUT BUSINESS SYSTEMS 50 ROCKWELL ROAD NEWINGTON, CT 06111	$ 6,250.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
36	JAD C. DEQUATTRO [redacted]	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37	HARTFORD RADIATION ONCOLOGY ASSOCIATES, P.C. 80 SEYMOUR STREET BOX 5037 HARTFORD, CT 06102-5037	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
38	MURTHA CULLINA LLP CITY PLACE 1, 185 ASYLUM STREET HARTFORD, CT 06103-3469	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
39	PRECISION COMPUTER SERVICES 175 CONSTITUTION BOULEVARD SOUTH SHELTON, CT 06484	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
40	JOHN F. SHEA [redacted]	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
41	VOYA FOUNDATION ONE ORANGE WAY, 3BN WINDSOR, CT 06095-4774	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
42	WAKEFERN 33 NORTHFIELD AVENUE EDISON, NJ 08818-7812	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43	STATE OF CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES 410 CAPITOL AVENUE HARTFORD, CT 06134	$ 103,773.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
44	US DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMIN. FOR CHILDREN AND FAMI JFK FEDERAL BUILDING, ROOM 2000 BOSTON, MA 02203	$ 526,831.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
45	STATE OF CT DEPARTMENT OF EDUCATION BOX 2219 HARTFORD, CT 06145	$ 203,913.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
46	STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES 25 SIGOURNEY STREET HARTFORD, CT 06106-5033	$ 530,729.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
47	STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH 410 CAPITOL AVENUE HARTFORD, CT 06134-0308	$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
48	STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH 410 CAPITOL AVENUE HARTFORD, CT 06134-0308	$ 32,872.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II if there is a noncash contribution.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49	STATE OF CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES 505 HUDSON STREET HARTFORD, CT 06106-7107	$ 107,771.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
48	VACCINES	$ 32,872.	09/30/13
		$	
		$	
		$	
		$	
		$	

Name of organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of $1,000 or less for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.**

OMB No. 1545-0047

2012

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax), or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		27,335.
j Total. Add lines 1c through 1i			27,335.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED THAT FOR ITS FISCAL YEAR THAT $16,804 OF ITS MEMBERSHIP DUES FROM MANCHESTER MEMORIAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE TOTAL LOBBYING PORTION FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA) FOR MANCHESTER MEMORIAL HOSPITAL WAS $10,531.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
- ☐ Preservation of land for public use (e.g., recreation or education)
- ☐ Protection of natural habitat
- ☐ Preservation of open space
- ☐ Preservation of an historically important land area
- ☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	9,747,173.	8,023,690.	8,100,283.	7,537,396.	7,346,972.
b Contributions					
c Net investment earnings, gains, and losses	1,854,875.	1,723,483.	-76,593.	562,887.	190,424.
d Grants or scholarships					
e Other expenditures for facilities and programs	1,200,000.				
f Administrative expenses					
g End of year balance	10,402,048.	9,747,173.	8,023,690.	8,100,283.	7,537,396.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 82.63 %
b Permanent endowment ▶ 15.32 %
c Temporarily restricted endowment ▶ 2.05 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)	X	
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b	X	

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,429,966.		1,429,966.
b Buildings		92,155,732.	50,421,837.	41,733,895.
c Leasehold improvements		1,687,509.	312,693.	1,374,816.
d Equipment		91,795,942.	83,220,149.	8,575,793.
e Other		2,280,179.	820,298.	1,459,881.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				54,574,351.

Schedule D (Form 990) 2012

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD UNDER BOND		
(B) INDENTURE	4,621,793.	END-OF-YEAR MARKET VALUE
(C) BENEFICIAL INTEREST IN		
(D) TRUST ASSETS	5,700,199.	END-OF-YEAR MARKET VALUE
(E) FUNDS HELD IN TRUST FOR		
(F) EST SELF INSURANCE LIAB	1,258,026.	END-OF-YEAR MARKET VALUE
(G)		
(H)		
(I)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	11,580,018.	

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INTEREST IN NET ASSTS OF		
(2) ECHN COMMUNITY HEALTHCARE		
(3) FOUNDATION, INC.	7,278,631.	END-OF-YEAR MARKET VALUE
(4) INVESTMENTS IN JOINT		
(5) VENTURES	3,501,635.	COST
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	10,780,266.	

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	25,434,604.
(2) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	9,214,370.
(3) OTHER	2,819,605.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	37,468,579.

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) CONDITIONAL RETIREMENT ASSET	
(3) OBLIGATIONS	279,796.
(4) OTHER CURRENT LIABILITIES	2,482,951.
(5) ESTIMATED SELF INSURANCE	
(6) LIABILITIES	6,830,954.
(7) ACCRUED PENSION AND POST	
(8) RETIREMENT BENEFITS	33,940,037.
(9) DUE TO AFFILIATES	7,220,571.
(10) DUE TO THIRD PARTY PAYERS	2,943,941.
(11) MARKET VALUE SWAP	129,775.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	53,828,025.

2. FIN 48 (ASC 740) Footnote. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII X

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	189,589,095.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	2,336,667.		
e	Add lines 2a through 2d			2e	2,336,667.
3	Subtract line 2e from line 1			3	187,252,428.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	758,365.		
c	Add lines 4a and 4b			4c	758,365.
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	188,010,793.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	189,801,785.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	877,685.		
e	Add lines 2a through 2d			2e	877,685.
3	Subtract line 2e from line 1			3	188,924,100.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	0.
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	188,924,100.

Part XIII Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4: THE PRINCIPAL AND INCOME FROM THE UNRESTRICTED ENDOWMENT FUNDS AND THE INCOME FROM THE TERM ENDOWMENTS ARE FOR CAPITAL AND OPERATING NEEDS OF MANCHESTER MEMORIAL HOSPITAL. THE INCOME FROM THE PERMANENT ENDOWMENTS AND PRINCIPAL FROM THE TERM ENDOWMENTS ARE FOR THE USE OF MANCHESTER MEMORIAL HOSPITAL AS RESTRICTED BY THE DONORS.

PART X, LINE 2: THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES," WHICH PROVIDES

Part XIII Supplemental Information *(continued)*

A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION.

THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2013 AND 2012. AS OF SEPTEMBER 30, 2013 AND 2012, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	362,792.
NET RENTAL LOSS	295,326.
NET ASSETS RELEASED FROM RESTRICTIONS FOR OPERATIONS	1,458,982.
FUNDRAISING EVENT EXPENSES	219,567.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	2,336,667.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARILY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	758,365.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	362,792.
NET RENTAL LOSS	295,326.
FUNDRAISING EVENT EXPENSES	219,567.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	877,685.

SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2 a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Schedule G (Form 990 or 990-EZ) 2012 MANCHESTER MEMORIAL HOSPITAL 06-0646710 Page 2

Part II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than $5,000.

		(a) Event #1 HEALIUM BALL (event type)	(b) Event #2 GOLF CLASSIC (event type)	(c) Other events NONE (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	361,616.	59,801.		421,417.
	2 Less: Contributions	282,617.	41,762.		324,379.
	3 Gross income (line 1 minus line 2)	78,999.	18,039.		97,038.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes		7,890.		7,890.
	6 Rent/facility costs	7,500.	9,897.		17,397.
	7 Food and beverages	68,392.	10,060.		78,452.
	8 Entertainment	21,690.			21,690.
	9 Other direct expenses	89,353.	4,785.		94,138.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(219,567.)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				-122,529.

Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	13a	%
b An outside facility	13b	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____ .

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Part IV **Supplemental Information.** Complete this part to provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 125 %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		X
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		2,500	1180482.	17,746.	1162736.	.62%
b Medicaid (from Worksheet 3, column a)		42,656	31162395.	22408793.	8753602.	4.63%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		45,156	32342877.	22426539.	9916338.	5.25%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	26	100,607	801,024.	820.	800,204.	.42%
f Health professions education (from Worksheet 5)	12	372	2043261.	1,300.	2041961.	1.08%
g Subsidized health services (from Worksheet 6)	1	191	2890946.	1462480.	1428466.	.76%
h Research (from Worksheet 7)	2	0	256,091.	0.	256,091.	.14%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	10	1,878	143,317.	0.	143,317.	.08%
j **Total.** Other Benefits	51	103,048	6134639.	1464600.	4670039.	2.48%
k **Total.** Add lines 7d and 7j	51	148,204	38477516.	23891139.	14586377.	7.73%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development			946.		946.	.00%
3	Community support		812	1390450.		1390450.	.74%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building			16,615.		16,615.	.01%
7	Community health improvement advocacy			4,891.		4,891.	.00%
8	Workforce development		25	337,699.		337,699.	.18%
9	Other						
10	Total		837	1750601.		1750601.	.93%

Part III Bad Debt, Medicare, & Collection Practices

				Yes	No
Section A. Bad Debt Expense					
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	5,518,461.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	3,908,882.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				
Section B. Medicare					
5	Enter total revenue received from Medicare (including DSH and IME)	5	47,264,369.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	56,191,186.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-8,926,817.		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other				
Section C. Collection Practices					
9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, and primary website address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group MANCHESTER MEMORIAL HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j [ ] Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3 In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	X	
5 Did the hospital facility make its CHNA report widely available to the public?	5	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website			
b [X] Available upon request from the hospital facility			
c [X] Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):			
a [X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b [X] Execution of the implementation strategy			
c [ ] Participation in the development of a community-wide plan			
d [ ] Participation in the execution of a community-wide plan			
e [ ] Inclusion of a community benefit section in operational plans			
f [ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g [X] Prioritization of health needs in its community			
h [X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i [ ] Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)* MANCHESTER MEMORIAL HOSPITAL

			Yes	No
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 125 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[X] Medical indigency			
d	[ ] Insurance status			
e	[ ] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[X] Other (describe in Part VI)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Part VI)			
Billing and Collections				
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			

Part V Facility Information *(continued)* MANCHESTER MEMORIAL HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☐ Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- d ☐ Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Part VI)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- d ☐ Other (describe in Part VI)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☒ Other (describe in Part VI)

21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI.	21		X
22 During the tax year, did the hospital facility charge any FAP-eligible individuals an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Part VI.	22		X

Part V Facility Information *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

PART II: MANCHESTER MEMORIAL HOSPITAL (MMH), AS PART OF EASTERN CONNECTICUT HEALTH NETWORK, PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. THROUGH GRANTS PROVIDED BY THE FEDERAL AND STATE GOVERNMENTS, MMH OFFERS FREE SUPPORT PROGRAMS TO PRENATAL INDIVIDUALS AND PARENTS TO PROMOTE POSITIVE FAMILY LIFE SKILLS AND CHILD DEVELOPMENT. IN FY 2013, THESE PROGRAMS BENEFITED 791 INDIVIDUALS WITH MMH PROVIDING NEARLY $110,000 OF IN-KIND RESOURCES AND SERVICES. OTHER COMMUNITY BUILDING ACTIVITIES INCLUDE SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; HOSTING ART EXHIBITS OF THE MANCHESTER ART ASSOCIATION; WORKING WITH THE MANCHESTER VETERANS COUNCIL TO HONOR VETERANS IN AN ANNUAL VETERANS DAY CEREMONY FOR THE COMMUNITY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY BOARD; THE DEPARTMENT OF PUBLIC HEALTH'S OFFICE OF EMERGENCY MEDICAL SERVICE MEDICAL ADVISORY

Part VI Supplemental Information

COMMITTEE AND NUMEROUS COMMUNITY COALITIONS THAT ADDRESS ADOLESCENT BEHAVIORAL HEALTH CONCERNS; AND SUPPORTING THE CHARITABLE EFFORTS OF THE MANCHESTER CHAPTER OF UNICO. AS A RESULT OF THESE ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

PART III, LINE 4: THE HOSPITAL PROVIDES FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE HOSPITAL OFFERS A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

Part VI Supplemental Information

PART III, LINE 8: THE HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL, REGARDLESS OF THEIR ABILITY TO PAY. CHARITY CARE IS PROVIDED TO THOSE WHO ARE ELIGIBLE BASED ON MMH'S POLICY. MMH ALSO INCURS UNPAID COSTS FOR GOVERNMENT PROGRAMS BECAUSE REIMBURSEMENT IS NOT SUFFICIENT TO COVER COSTS ASSOCIATED WITH MEDICARE AND MEDICAID PATIENTS. THE ORGANIZATION'S MEDICARE COST REPORT WAS USED TO CALCULATE ACTUAL COSTS REPORTED ON PART III, LINE 6. THE ACCESS TO HEALTHCARE BY PATIENTS COVERED BY MEDICARE IS A FUNDAMENTAL PART OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM.

PART III, LINE 9B: INTERNAL AND EXTERNAL COLLECTION POLICIES AND PROCEDURES TAKE INTO ACCOUNT THE EXTENT TO WHICH A PATIENT IS QUALIFIED FOR CHARITY CARE OR DISCOUNTS. IN ADDITION, PATIENTS WHO QUALIFY FOR PARTIAL DISCOUNTS ARE REQUIRED TO MAKE A GOOD FAITH EFFORT TO HONOR PAYMENT AGREEMENTS WITH THE HOSPITAL, INCLUDING PAYMENT PLANS AND DISCOUNTED HOSPITAL BILLS. MMH IS COMMITTED TO WORKING WITH PATIENTS TO RESOLVE THEIR ACCOUNTS, AND AT ITS DISCRETION, MAY PROVIDE EXTENDED PAYMENT PLANS TO ELIGIBLE PATIENTS. MMH WILL NOT PURSUE LEGAL ACTION FOR NON-PAYMENT OF BILLS AGAINST CHARITY CARE PATIENTS WHO HAVE COOPERATED WITH THE HOSPITAL TO RESOLVE THEIR ACCOUNTS AND HAVE DEMONSTRATED THEIR INCOME AND/OR ASSETS ARE INSUFFICIENT TO PAY MEDICAL BILLS.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 3: AS PART OF ITS CHNA, MMH INVITED COMMUNITY AGENCIES AND ORGANIZATIONS THROUGHOUT THE SERVICE AREA, REPRESENTING A VARIETY OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS, TO PARTICIPATE IN AN ONLINE SURVEY, WHICH ASKED QUESTIONS ABOUT WHAT THE INDIVIDUALS PERCEIVED TO BE HEALTHY AND UNHEALTHY ABOUT THE COMMUNITY, WHAT THEIR PERCEPTION IS OF MMH AND THE PROGRAMS AND SERVICES IT OFFERS,

Part VI Supplemental Information

AND WHAT MMH CAN DO TO IMPROVE THE HEALTH AND QUALITY OF LIFE IN THE COMMUNITY. AGENCIES AND ORGANIZATIONS RESPONDING TO THE SURVEY INCLUDED THE DEPARTMENT OF PUBLIC HEALTH WIC PROGRAM, COMMUNITY CHILD GUIDANCE CLINIC, VERNON YOUTH SERVICES BUREAU, TOWN OF ELLINGTON HUMAN SERVICES, TOWN OF MANCHESTER HEALTH DEPARTMENT, TOWN OF ANDOVER ELDER SERVICES, MAPLE STREET SCHOOL IN VERNON, VERNON ADULT EDUCATION, INDIAN VALLEY YMCA, AND MARC, INC.

MANCHESTER MEMORIAL HOSPITAL:
PART V, SECTION B, LINE 4: THE CHNA WAS CONDUCTED BY EASTERN CONNECTICUT HEALTH NETWORK, WHICH INCLUDES MANCHESTER MEMORIAL HOSPITAL AND ROCKVILLE GENERAL HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:
PART V, SECTION B, LINE 5C: HTTP://WWW.ECHN.ORG/FILES/COMMUNITY-BENEFITS/MMH-AND-RGH-CHNA-2013-FINAL-REPORT.ASPX

MANCHESTER MEMORIAL HOSPITAL:
PART V, SECTION B, LINE 7: AFTER REVIEWING THE CHNA DATA, THE OVERSIGHT COMMITTEE IDENTIFIED EIGHT HEALTH AREAS OF NEED (HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE, ARTHRITIS INCIDENCE, ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING), HOWEVER IT WAS DETERMINED THAT ALL NEEDS COULD NOT BE ADDRESSED BASED ON THE HOSPITAL'S ABILITY TO IMPACT THE NEEDS AND THE AVAILABILITY OF RESOURCES THAT EXIST TO ADDRESS THEM. THE FOLLOWING

Part VI Supplemental Information

HEALTH NEEDS WERE IDENTIFIED AS THE HIGHEST PRIORITY: HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE AND ARTHRITIS INCIDENCE.

THE COMMUNITY HEALTH NEEDS ASSESSMENT AND THE STRATEGIES TO ADDRESS THE PRIORITY NEEDS IDENTIFIED (IMPLEMENTATION PLAN) WERE REVIEWED AND APPROVED BY THE ECHN STRATEGIC PLANNING COMMITTEE ON AUGUST 21, 2013. THE ECHN BOARD OF TRUSTEES REVIEWED AND APPROVED THE CHNA AND IMPLEMENTATION PLAN ON SEPTEMBER 25, 2013.

MANCHESTER MEMORIAL HOSPITAL:
PART V, SECTION B, LINE 12H: FAMILY SIZE IS USED WITH INCOME LEVEL.

MANCHESTER MEMORIAL HOSPITAL:
PART V, SECTION B, LINE 20D: CHARGES ARE UNIFORMLY SET FOR ALL PATIENTS REGARDLESS OF PAYOR AND CHARITY CARE DISCOUNT IS APPLIED BASED ON INCOME.

PART VI, LINE 2: IN 2013, MMH COLLABORATED WITH ROCKVILLE GENERAL HOSPITAL, ALSO AN AFFILIATE OF ECHN, TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE GOALS OF THE ASSESSMENT WERE: TO IDENTIFY CURRENT AND FUTURE HEALTHCARE NEEDS IN THE COMMUNITY AND TO IMPROVE AND STRENGTHEN PROGRAMS AND SERVICES PROVIDED TO ADDRESS THEM.

THE CHNA PROCESS WAS LED BY AN OVERSIGHT COMMITTEE THAT INCLUDED MEMBERS OF THE ORGANIZATION WITH ESTABLISHED RELATIONSHIPS WITH COMMUNITY GROUPS AND AGENCIES. DATA COLLECTED FOR THE CHNA INCLUDED: HEALTH, SOCIAL, AND

Part VI Supplemental Information

DEMOGRAPHIC DATA SPECIFIC TO MMH'S SERVICE AREA OBTAINED FROM LOCAL PUBLIC HEALTH AGENCIES, NATIONAL HEALTH ASSOCIATIONS AND OTHER DATA SOURCES; HEALTH BEHAVIOR INFORMATION COLLECTED FROM 1,047 RESIDENTS WHO RESPONDED TO A COMMUNITY SURVEY; INPUT FROM 12 COMMUNITY STAKEHOLDERS FROM LOCAL ORGANIZATIONS INVESTED IN THE HEALTH OF UNDERSERVED POPULATIONS.

ONCE ALL DATA WAS COLLECTED AND ANALYZED, THE OVERSIGHT COMMITTEE IDENTIFIED AND PRIORITIZED THE SERVICE AREA'S KEY HEALTH NEEDS AND DEVELOPED AN IMPLEMENTATION STRATEGY TO RESPOND TO THE NEEDS.

PART VI, LINE 3: THE HOSPITAL COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE THROUGH NOTICES POSTED IN PUBLIC AREAS AROUND THE HOSPITAL, ON THE PATIENT BILLS, ON OUR WEBSITE, AND SELECTED PRE-SCHEDULED SERVICES TO ENSURE THAT THE FINANCIAL CAPACITY OF PEOPLE WHO NEED HEALTHCARE SERVICES DOES NOT PREVENT THEM FROM SEEKING OR RECEIVING CARE.

PART VI, LINE 4: MANCHESTER MEMORIAL HOSPITAL, AS PART OF EASTERN CONNECTICUT HEALTH NETWORK, SERVES A 19-TOWN PRIMARY AND SECONDARY SERVICE AREA LOCATED EAST OF THE CONNECTICUT RIVER IN NORTHERN CONNECTICUT WITH MUNICIPALITIES IN HARTFORD, TOLLAND AND WINDHAM COUNTIES. THE PRIMARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO 20 PERCENT AND INCLUDES THE TOWNS OF MANCHESTER, SOUTH WINDSOR, BOLTON, COVENTRY, ANDOVER, ELLINGTON, TOLLAND, VERNON/ROCKVILLE AND WILLINGTON. THE SECONDARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO FIVE PERCENT AND LESS THAN 20 PERCENT AND INCLUDES THE TOWNS OF ASHFORD, SOMERS, STAFFORD, UNION, EAST HARTFORD, EAST WINDSOR, GLASTONBURY, HEBRON, COLUMBIA AND MANSFIELD.

Part VI Supplemental Information

BASED ON DATA COLLECTED IN 2013, THE POPULATION OF THE ENTIRE SERVICE AREA IS 341,000; 49% MALE, 51% FEMALE. THE MEDIAN AGE OF RESIDENTS IS 39.5 YEARS WITH 33.3% OF THE POPULATION 50 YEARS OR OLDER. THE RACE OF THE RESIDENTS IS PREDOMINANTLY WHITE (80%) FOLLOWED BY BLACK/AFRICAN AMERICAN (8.3%), OTHER/MULTI-RACE (6.1%) AND ASIAN (5.3%). APPROXIMATELY 91.5% PERCENT OF THE POPULATION HAS A HIGH SCHOOL DEGREE AND 35.6% PERCENT HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME FOR THE SERVICE AREA IS $82,075 PER YEAR. JUST UNDER 8% OF HOUSEHOLDS HAVE ANNUAL INCOME AT THE FEDERAL POVERTY RATE. THE UNEMPLOYMENT RATE IS 7.4% AND THE AVERAGE HOUSEHOLD SIZE IS 2.61 PEOPLE.

PART VI, LINE 5: COMMUNITY HEALTH EDUCATION INITIATIVES AND PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE FREE COMMUNITY HEALTH EDUCATIONAL PROGRAMS, EDUCATION IN BETTER BEING (A FREE COMMUNITY WELLNESS MAGAZINE), PARTICIPATION IN COMMUNITY HEALTH FAIRS, THE DEVELOPMENT OF "FREEDOM FROM SMOKING" SMOKING CESSATION PROGRAM, NUTRITION COUNSELING SERVICES, INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, THE PROMOTION OF CARDIAC REHABILITATION SERVICES, FREE CANCER SCREENINGS, ONCOLOGY NURSE NAVIGATOR AND SURVIVORSHIP NAVIGATORS SERVICES, ANNUAL CANCER SURVIVORS DAY EVENT, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES AND LECTURE PRESENTATIONS. THE EDUCATION PROGRAMS INCLUDE EDUCATING THE PUBLIC ABOUT MANAGING LIFESTYLE BEHAVIORS THAT IMPACT DIET, BLOOD PRESSURE, CHOLESTEROL, WEIGHT, PHYSICAL ACTIVITY, STRESS, CANCER RISKS, DIABETES AND ARTHRITIS.

Part VI Supplemental Information

FREE HEALTH SCREENINGS INCLUDING DIABETIC FOOT CHECKS, PROSTATE AND SKIN CANCER SCREENINGS, MAMMOGRAMS, BLOOD PRESSURE, BONE DENSITY, GLUCOSE READINGS, INJURY SCREENINGS, VITAL SIGN CHECKS AND MEDICAL EXAMS ARE OFFERED IN THE COMMUNITY, TARGETING UNINSURED/UNDERINSURED POPULATIONS.

HEALTHCARE SUPPORT SERVICES ARE PROVIDED BY THE HOSPITAL TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS IN NEED. EFFORTS INCLUDE FREE TRANSPORTATION TO BEHAVIORAL HEALTH PATIENTS, ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, REFERRALS TO SOCIAL SERVICES AND PHYSICIANS ACCEPTING MEDICAID OR OTHER GOVERNMENT PROGRAMS, AND FREE LIFELINE PERSONAL RESPONSE SYSTEM SERVICE.

PARTNERING WITH LOCAL EDUCATIONAL INSTITUTIONS, MANCHESTER MEMORIAL HOSPITAL PROVIDES A CLINICAL SETTING FOR PHYSICIANS, NURSES, RADIOLOGIC TECHNICIANS, RESPIRATORY TECHNICIANS AND PHYSICAL THERAPISTS AND OTHERS FROM THE UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, UNIVERSITY OF CONNECTICUT, MANCHESTER COMMUNITY COLLEGE, CENTRAL CONNECTICUT STATE UNIVERSITY, GOODWIN COLLEGE, CAPITAL COMMUNITY COLLEGE, ST. JOSEPH® COLLEGE, QUINNIPIAC UNIVERSITY, UNIVERSITY OF HARTFORD, NAUGATUCK VALLEY COMMUNITY COLLEGE AND EASTERN CONNECTICUT STATE UNIVERSITY.

SPECIFIC RESEARCH INITIATIVES CONDUCTED BY THE HOSPITAL INCLUDE MAINTENANCE OF A CANCER REGISTRY DATABASE AND AN INSTITUTIONAL REVIEW COMMITTEE. FINANCIAL AND IN-KIND SERVICES AND GOODS ARE DONATED TO COMMUNITY GROUPS AND OTHER NOT FOR PROFIT ORGANIZATIONS INCLUDING PATIENT MEALS, LOCAL FUNDRAISERS, FACILITY SPACE TO HOST BLOOD DRIVES AND HEALTH SUPPORT GROUPS ORGANIZATIONS' MEETINGS.

PART VI, LINE 6: MANCHESTER MEMORIAL HOSPITAL (MMH) IS AN AFFILIATE OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), A HEALTH CARE SYSTEM SERVING 19 TOWNS IN EASTERN CONNECTICUT. THE ECHN NETWORK OF AFFILIATES INCLUDES:

MMH, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC & PULMONARY REHABILITATION, A COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, AND THE EASTERN CONNECTICUT CANCER INSTITUTE AT THE JOHN A. DEQUATTRO CANCER CENTER. ROCKVILLE GENERAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 102 BEDS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, CARDIAC & PULMONARY REHABILITATION, PHYSICAL REHABILITATION, HOSPICE CARE, A MATERNITY CARE CENTER FOR UNINSURED WOMEN, OUTPATIENT ADOLESCENT BEHAVIORAL HEALTH SERVICES, AND LABORATORY SERVICES.

WOODLAKE AT TOLLAND IS A SKILLED NURSING & REHABILITATION CENTER, A 130-BEDLONG-TERM SKILLED NURSING CARE AND SHORT-TERM REHABILITATION FACILITY. CUSTOMIZED REHABILITATION TREATMENT SERVICES INCLUDE JOINT REPLACEMENT REHABILITATION, ORTHOPEDIC POST-HOSPITAL CARE, STROKE/NEUROLOGICAL REHAB, POST MEDICAL/SURGICAL RECONDITIONING, AND PERSONALIZED, PROGRESSIVE, AND INTERDISCIPLINARY CARE SERVICES.

EASTERN CONNECTICUT MEDICAL PROFESSIONALS (ECMPF) FOUNDATION, INC., A

Part VI Supplemental Information

MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOMERS, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE. GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES. ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR); 2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, AND ECMP PRIMARY CARE, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, AND LABORATORY SERVICES. 2600 TAMARACK AVENUE INCLUDES THE WOMEN'S CENTER FOR WELLNESS, ECHN BREAST CARE COLLABORATIVE, AND THE OB/GYN GROUP OF EASTERN CONNECTICUT. 2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES, INCLUDING ORTHOPEDIC SURGERY, OTOLARYNGOLOGY (ENT), AND GENERAL SURGERY, CORPCARE, AND SOUTH WINDSOR URGENT CARE. ECHN MANCHESTER MEDICAL OFFICE BUILDINGS: 150 NORTH MAIN STREET OFFERS A VARIETY OF BEHAVIORAL HEALTH SERVICES. VISITING NURSE & HEALTH SERVICES OF CONNECTICUT PROVIDES AT-HOME NURSING CARE AND HOSPICE CARE. ECHN HAS 432 PHYSICIANS (317 ACTIVE, 65 COURTESY, 12 CONSULTING, 38 PART-TIME), 83 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16 SERVICES AS WELL AS 15 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO CARE FOR THE COMMUNITY.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

Part VI Supplemental Information

ADDITIONAL INFORMATION:

MANCHESTER MEMORIAL HOSPITAL IS A NOT-FOR-PROFIT 249-BED ACUTE CARE HOSPITAL THAT PROVIDES INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES FOR RESIDENTS OF MANCHESTER, CT AND SURROUNDING TOWNS. THE HOSPITAL IS A SUBSIDIARY OF EASTERN CONNECTICUT HEALTH NETWORK, INC., WHICH WAS FORMED IN 1995 BY A MERGER OF MMH CORP. AND ROCKVILLE AREA HEALTH SERVICES, INC. ECHN WAS ORGANIZED TO PROVIDE A BROADER HEALTH CARE SYSTEM FOR THE SURROUNDING COMMUNITIES WITH QUALITY MEDICAL CARE AT A REASONABLE COST AND TO FOSTER AN ENVIRONMENT CONDUCIVE TO HEALTH AND WELL BEING WHETHER IN THE HOME OR IN THE COMMUNITY.

MANCHESTER MEMORIAL HOSPITAL PATIENTS NOT HAVING INSURANCE COVERING EMERGENCY OR OTHER MEDICALLY QUALIFIED CARE (UNINSURED PATIENTS), AS WELL AS UNDERINSURED PATIENTS, SUBJECT TO INCOME LIMITS AND FAMILY SIZE RECEIVE FREE OR DISCOUNTED CARE. MANCHESTER MEMORIAL HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. CHARGES FOR CARE PROVIDED TO PATIENTS ARE DETERMINED BY ESTABLISHED RATES, SUBJECT TO POSSIBLE ADJUSTMENTS OR DISCOUNTS FOR LOW INCOME PATIENTS; CONTRACTUAL DISCOUNTS, OR DISCOUNTS FOR PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES. CHARITY CARE FOR FY 2013 WAS $3,908,882 FOR 2,500 TOTAL APPROVED APPLICANTS.

EXPENSES RELATED TO SERVICES PERFORMED FOR PATIENTS OF MANCHESTER MEMORIAL HOSPITAL CONTRIBUTE IMPORTANTLY TO ITS EXEMPT PURPOSE BECAUSE THE EXPENSES ARE INCURRED IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT AND PREVENTION OF DISEASE, AND FOR MEDICAL PURPOSES AFFECTING THE STRUCTURE OR FUNCTION OF THE HUMAN BODY.

Part VI | Supplemental Information

MANCHESTER MEMORIAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY. NINE THOUSAND THREE HUNDRED FORTY-TWO (9,342) INPATIENTS WERE CARED FOR IN FY13 REPRESENTING 46,662 PATIENT DAYS. TWO HUNDRED SEVENTY THOUSAND FIVE HUNDRED FIFTY-SIX (270,556) OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 9,342 INPATIENTS WERE 5,947 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	3,013
MEDICARE MANAGED CARE	808
MEDICAID	2,085
CHAMPUS	41
TOTAL GOV PATIENTS	5,947
TOTAL NON GOV PATIENTS	3,395
TOTAL PATIENTS	9,342

INCLUDED IN THE 270,556 OUTPATIENT VISITS WERE 151,329 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	84,871
MEDICARE MANAGED CARE	26,781
MEDICAID	38,721
CHAMPUS	956

Part VI Supplemental Information

TOTAL GOV PATIENTS 151,329

TOTAL NON GOV PATIENTS 119,227

TOTAL OUTPATIENT VISITS 270,556

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 42,656 MEDICAID PATIENTS FOR A NET COMMUNITY BENEFIT AMOUNT OF $8,753,603 AFTER MEDICAID REIMBURSEMENT.

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I **General Information on Grants and Assistance**

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II **Grants and Other Assistance to Governments and Organizations in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... ▶

3 Enter total number of other organizations listed in the line 1 table ..... ▶

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990.** **Schedule I (Form 990) (2012)**

232101
12-18-12

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
SCHOLARSHIPS	14	14,650.	0.		

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

SCHEDULE I, PART I, LINE 2: THE SCHOLARSHIPS ARE AWARED TO ECHN EMPLOYEES WISHING TO FURTHER THEIR NURSING EDUCATION OR BECOME A NURSE. THE PRIMARY PURPOSE IS TO PROVIDE FINANCIAL ASSISTANCE TO ECHN EMPLOYEES ENROLLED IN AN ACCREDITED NURSING PROGRAM THAT LEADS TO BECOMING A REGISTERED NURSE. FURTHERMORE, A PORTION OF THE FUNDS MAY BE AWARDED TO AN ECHN REGISTERED NURSE TO ASSIST THAT PERSON IN OBTAINING AN ADVANCED DEGREE. SCHOLARSHIPS ARE AWARDED BASED ON THE DETERMINATION OF A NURSING SCHOLARSHIP COMMITTEE. NURSING STUDENTS WHO NEED FINANCIAL ASSISTANCE TO COMPLETE THEIR EDUCATION AND WHO DEMONSTRATE SCHOLASTIC ABILITY AND PROFESSIONAL PROMISE ASE

Part IV Supplemental Information

ELIGIBLE IF THEY ARE AN EMPLOYEE OF AN ECHN AFFILIATE, AT LEAST 20 HOURS PART-TIME OR FULL-TIME, FOR AT LEAST ONE YEAR; AND CURRENTLY ENROLLED IN AN ACCREDITED TRADITIONAL OR NON-TRADITIONAL NURSING PROGRAM. BACCALAUREATE APPLICANTS MUST HAVE COMPLETED THE 2ND YEAR OF A 4-YEAR PROGRAM AND ASSOCIATE DEGREE APPLICANTS MUST HAVE COMPLETED ALL PREREQUISITES AND BE ACCEPTED INTO A NURSING PROGRAM. IN MAKING THE AWARDS, THE COMMITTEE USES JOB PERFORMANCE EVALUATION AND RECOMMENDATION, GRADE POINT AVERAGE AND PROFESSIONAL GOALS. IN ADDITION, THE NUMBER OF CREDITS IN WHICH AN APPLICANT IS ENROLLED AND THE COST PER CREDIT IS FACTORED INTO ANY AWARD. IF AWARDED A SCHOLARSHIP, THE RECIPIENT AGREES TO MAINTAIN EMPLOYMENT, WHETHER FULL OR PART-TIME, AT AN AFFILIATE OF ECHN FOR A MINIMUM OF ONE YEAR. AWARDS ARE MAILED DIRECTLY TO THE EDUCATIONAL INSTITUTION.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 23.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL	(i)	571,136.	198,000.	0.	90,000.	23,819.	882,955.	0.
PRESIDENT AND CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) KEVIN G. MURPHY	(i)	365,827.	105,604.	0.	42,701.	23,869.	538,001.	0.
EVP, TREASURER	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) MICHAEL D. VEILLETTE	(i)	289,379.	65,804.	0.	25,126.	20,937.	401,246.	0.
SVP, CHIEF FINANCIAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) DEBORAH GOGLIETTINO	(i)	234,772.	56,400.	0.	25,125.	16,625.	332,922.	0.
SVP, HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DENNIS MCCONVILLE	(i)	212,785.	48,990.	0.	74,088.	9,385.	345,248.	0.
SVP, STRATEGIC PLANNING	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) DEBORAH PARKER	(i)	263,589.	72,400.	0.	30,000.	22,120.	388,109.	0.
EVP, CHIEF CLINICAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JOEL REICH, M.D.	(i)	325,831.	74,753.	0.	103,200.	15,917.	519,701.	0.
SVP, MEDICAL AFFAIRS	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) CHARLES COVIN	(i)	198,967.	16,000.	0.	23,238.	15,246.	253,451.	0.
VP AND CIO	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) LEONA CROSSKEY	(i)	146,452.	26,268.	0.	48,609.	20,557.	241,886.	0.
VP, QUALITY	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) ROBERT CARROLL, M.D.	(i)	395,608.	133,057.	0.	7,500.	20,637.	556,802.	0.
MED DIR, EMERGENCY DEPARTMENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JAMES A. CASTELLONE,, M.D.	(i)	366,854.	46,358.	0.	7,500.	2,430.	423,142.	0.
ASST. MED DIR, EMERGENCY DEPARTMENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) SCOTT BROWN, M.D.	(i)	259,696.	117,888.	0.	7,500.	21,517.	406,601.	0.
DOCTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ANDREAS J. BOJKO, M.D.	(i)	280,069.	111,585.	0.	47,899.	21,516.	461,069.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) ENOCH DARKO, M.D.	(i)	258,171.	106,405.	0.	7,500.	2,430.	374,506.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) THEODORE SHERRY, M.D.	(i)	245,828.	125,010.	0.	7,500.	21,516.	399,854.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) KATHLEEN SIMS	(i)	88,279.	31,475.	0.	6,042.	10,060.	135,856.	0.
FORMER VP, OPERATIONS	(ii)	0.	0.	0.	0.	0.	0.	0.

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 3: THE BOARD OF TRUSTEES (THE "BOARD") APPOINTS AN EXECUTIVE COMPENSATION COMMMITTEE (THE "COMMITTEE") AND HAS DELEGATED THE RESPONSIBILITY OF COMPLETING AN ANNUAL MARKET ANALYSIS OF THE CEO'S COMPENSATION AND OTHER SENIOR EXECUTIVES AND COMPLETION OF THE CEO'S ANNUAL PERFORMANCE REVIEW.

THE EVALUATION OF THE CEO IS AN IMPORTANT RESPONSIBILITY OF THE BOARD AND IS CRITICAL TO THE GOVERNANCE RESPONSIBILITIES OF THE BOARD. THE EXECUTIVE COMPENSATION COMMITTEE SOLICITS FEEDBACK ABOUT THE PERFORMANCE OF THE CEO FROM EVERY ACTIVE BOARD MEMBER WHICH WHEN RECEIVED IS ANALYZED AND REVIEWED BY THE MEMBERS OF THE COMMITTEE. THE CEO COMPLETES A SELF-EVALUATION AND AN EVALUATION FOR ALL ELIGIBLE MEMBERS OF THE SENIOR LEADERSHIP TEAM, WHO COMPLETE BOTH A SELF-EVALUATION AND A PEER EVALUATION. THE RESULTS OF THE ASSESSMENTS COMPLETED BY MEMBERS OF THE SENIOR LEADERSHIP TEAM ARE REVIEWED BY THE CEO WHO DISCUSSES THE RESULTS WITH THE MEMBERS OF THE COMMITTEE ON AN ANNUAL BASIS.

THE EXECUTIVE COMPENSATION COMMITTEE IN COLLABORATION WITH THE CEO

Part III | Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

EVALUATES AND APPROVES ORGANIZATIONAL PERFORMANCE OBJECTIVES BOTH ON AN ANNUAL AND LONG TERM BASIS AND FOCUSES ON THOSE GOALS WITH THE GREATEST IMPACT TO THE ORGANIZATION'S STRATEGY AND MISSION. THE COMMITTEE ENSURES AN ANNUAL REVIEW OF THE CEO'S PERFORMANCE IN RELATION TO THESE GOALS; REVIEWS THE TALLY SHEETS TO UNDERSTAND THE ECONOMICS OF THE EMPLOYEE BENEFITS; RETAINS AND ENSURES THE INDEPENDENCE OF ITS EXTERNAL CONSULTANTS AND ADVISORS AND INVOLVES RELEVANT ORGANIZATIONAL RESOURCES AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES.

THE COMMITTEE ENSURES TRANSPARENCY AND DISCLOSURE TO THE BOARD BY PRESENTING THE RESULTS OF THE ANNUAL PERFORMANCE AND MARKET REVIEWS PROVIDING THE BOARD WITH THE OPPORTUNITY FOR FURTHER INPUT AND CONSIDERATION AND ASKING THAT THE BOARD TAKE ACTION ON THE RECOMMENDATION OF THE COMMITTEE IF THE RECOMMENDATION IS APPROPRIATE. THE BOARD HAS THE OPPORTUNITY TO CHANGE ANY RECOMMENDATIONS OF THE COMMITTEE IF IT SO DESIRES. MEMBERS OF THE BOARD AND OF THE COMMITTEE WHO MAY BE INTERESTED PARTIES ARE ASKED TO RECUSE THEMSELVES FROM ANY REQUIRED VOTES TO AVOID CONFLICTS OF INTEREST. THE COMMITTEE ENSURES THAT THE PROCESS MEETS COMPLIANCE STANDARDS.

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 4B:

PETER KARL - $82,500

KEVIN MURPHY - $35,201

MICHAEL VEILLETTE - $17,626

DEBORAH GOGLIETTINO - $17,625

DEBORAH PARKER - $22,500

DENNIS MCCONVILLE - $15,975

JOEL REICH - $25,500

PART I, QUESTIONS 5A, 5B, 6A AND 6B: THE ECHN EXECUTIVE INCENTIVE COMPENSATION PLAN IS A PLAN THAT HAS BEEN DEVELOPED, REVIEWED AND IS ANNUALLY APPROVED BY MEMBERS OF THE BOARD EXECUTIVE COMPENSATION COMMITTEE WITH CONSULTANT THIRD PARTY OVERSIGHT.

THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

(WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF THE INCENTIVE PROGRAM.

THERE IS NO EXECUTIVE COMPENSATION TIED TO THE REVENUES OF THE REPORTING ORGANIZATION OR OTHER RELATED ENTITIES. THERE IS EXECUTIVE COMPENSATION TIED TO THE NET EARNINGS (INCOME FROM OPERATIONS), AS NOTED IN THE PRIOR PARAGRAPH, HOWEVER IT IS ONE OF FOUR PERFORMANCE LEVERS THAT DETERMINE THE LEVEL OF COMPENSATION. THE AGGREGATE NET EARNINGS OF THE ECHN "SYSTEM" NOT ANY ONE REPORTING ORGANIZATION OR RELATED ENTITIES OF ECHN DETERMINE THIS COMPENSATION. SO TO CONCLUDE, THE ANSWER TO THESE 4 QUESTIONS IS "NO" WITH THE CLARIFICATION THAT IT IS THE PERFORMANCE OF THE ENTIRE SYSTEM AS A WHOLE THAT DETERMINES EXECUTIVE COMPENSATION, NOT ONE REPORTING ORGANIZATION OR A RELATED ENTITY.

MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE - KEY EMPLOYEE NAME

PRESIDENT AND CEO - PETER J. KARL

EVP, TREASURER - KEVIN G. MURPHY

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SVP, CHIEF FINANCIAL OFFICER - MICHAEL D. VEILLETTE

SVP, HUMAN RESOURCES - DEBORAH GOGLIETTINO

SVP, STRATEGIC PLANNING - DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER - DEBORAH PARKER

SVP, MEDICAL AFFAIRS - JOEL REICH, M.D.

VP AND CIO - CHARLES COVIN

VP QUALITY - LEONA CROSSKEY

VP, OPERATIONS - KATHLEEN SIMS

MED. DIR. EMERGENCY DEPARTMENT - ROBERT CARROLL, M.D.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization: MANCHESTER MEMORIAL HOSPITAL
Employer identification number: 06-0646710

Part I Bond Issues SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pooled financing Yes	(i) Pooled financing No
A	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774UAZ8	11/09/05	37579404.	ADVANCE REFUND AND DEFEASE A POR		X		X		X
B	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	NONEAVAIL	05/14/09	15250000.	WOODLAKE EXPANSION, EQUIPM		X		X		X
C	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774U5W1	12/21/10	20145000.	REDEEM PRIOR ISSUE AND FUND IN		X		X		X
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	37,579,404.	15,250,000.	20,145,000.	
4	Gross proceeds in reserve funds	3,556,957.		1,065,002.	
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	32,759,288.	9,966,919.	17,048,821.	
7	Issuance costs from proceeds	632,013.	305,000.	402,900.	
8	Credit enhancement from proceeds	631,146.		92,225.	
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		4,978,081.		
11	Other spent proceeds			1,536,052.	
12	Other unspent proceeds				
13	Year of substantial completion	2006	2009	2011	

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
14	Were the bonds issued as part of a current refunding issue?		X	X		X			
15	Were the bonds issued as part of an advance refunding issue?	X			X		X		
16	Has the final allocation of proceeds been made?	X		X		X			
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X			

Part III Private Business Use

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		

Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	.00 %		.00 %		.00 %		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	.00 %		.00 %		.00 %		%	
6 Total of lines 4 and 5	.00 %		.00 %		.00 %		%	
7 Does the bond issue meet the private security or payment test?	X		X		X			
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X		X		

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T?		X		X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		
b Exception to rebate?		X	X			X		
c No rebate due?	X			X		X		
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X	X		X			
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X			X		
b Name of provider			TD BANK					
c Term of hedge			5.0000000					
d Was the hedge superintegrated?			X					
e Was the hedge terminated?				X				

Part IV Arbitrage *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X			

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES C
(F) DESCRIPTION OF PURPOSE:
ADVANCE REFUND AND DEFEASE A PORTION OF THE SERIES 2000A BONDS (C)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES D
(F) DESCRIPTION OF PURPOSE:
WOODLAKE EXPANSION, EQUIPMENT PURCHASE, REFUNDING PRIOR ISSUE (SER D)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES E
(F) DESCRIPTION OF PURPOSE:
REDEEM PRIOR ISSUE AND FUND INTEREST RATE SWAP TERMINATION PAYMENTS

THE SERIES C BONDS WERE ISSUED AFTER 12/31/02 TO REFUND BONDS ISSUED BEFORE 1/1/2003. AS A RESULT, LINES 1 - 9 OF PART III ARE NOT REQUIRED TO BE COMPLETED.

DATE OF LAST ARBITRAGE REBATE CALCULATION:
SERIES C REBATE COMPUTATION WAS DONE 11/9/2010.

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 (a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	(d) Corrected? No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	(d) From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) No	(h) Approved by board or committee? Yes	(h) No	(i) Written agreement? Yes	(i) No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
DR. DENNIS O'NEILL & DR. M	SEE PART V	390,541.	SEE PART V		X
KATHLEEN O'NEILL	SEE PART V	0.	SEE PART V		X

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DR. DENNIS O'NEILL & DR. MICHELE CONLON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (1)

(C) AMOUNT OF TRANSACTION $ 390,541.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

ECPC CONTRACTS WITH ECHN, INC. TO PROVIDE PATHOLOGY SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING CASHFLOW; PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS. THE 6 OWNERS ARE ALSO WORKING PATHOLOGISTS ALONG WITH TWO PHYSICIAN ASSISTANTS TO MAKE UP THE 8 EMPLOYEES OF THE PRACTICE.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (2)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

(E) SHARING OF ORGANIZATION REVENUES? = NO

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(1) MMH TRUSTEES EACH OWNING MORE THAN 5% OF EASTERN CONNECTICUT PATHOLOGY CONSULTANTS, PC (ECPC) AND TWO OF SIX TOTAL OWNERS OF ECPC.

(2) MMH TRUSTEE AND THE WIFE OF DR. DENNIS O'NEILL, TRUSTEE FOR ALL AFFILIATES, WHO HAS A REPORTABLE TRANSACTION AS NOTED ABOVE.

SCHEDULE L, PART IV, COLUMN (C):

PAYMENT OF $390,541 FROM MMH IS TO ECPC AND NOT DIRECTLY TO ANY OF THE OWNERS OF ECPC.

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art - Works of art				
2	Art - Historical treasures				
3	Art - Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities - Publicly traded				
10	Securities - Closely held stock				
11	Securities - Partnership, LLC, or trust interests				
12	Securities - Miscellaneous				
13	Qualified conservation contribution - Historic structures				
14	Qualified conservation contribution - Other				
15	Real estate - Residential				
16	Real estate - Commercial				
17	Real estate - Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies	X	1	32,872.	COST
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ ( )				
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement 29 0

			Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1-28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		X
b	If "Yes," describe the arrangement in Part II.			
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	31		X
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a		X
b	If "Yes," describe in Part II.			
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.			

Part II **Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

SCHEDULE O (Form 990 or 990-EZ)
Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization: MANCHESTER MEMORIAL HOSPITAL
Employer identification number: 06-0646710

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

FORM 990, PART III, LINE 4D, OTHER PROGRAM SERVICES:

SEE SCHEDULE H, PART VI

EXPENSES $ 92,905,840. INCL GRANTS OF $ 14,650. REVENUE $ 102,286,817.

FORM 990, PART VI, SECTION A, LINE 2: BOARD MEMBERS DENNIS O'NEILL AND MICHELE CONLON ARE BUSINESS PARTNERS.

FORM 990, PART VI, SECTION A, LINE 6: ECHN IS THE SOLE MEMBER OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A: ECHN HAS THE AUTHORITY TO ELECT TRUSTEES AND OFFICERS AND APPOINT COMMITTEE MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7B: ECHN HAS VARIOUS POWERS INCLUDING BUT NOT LIMITED TO: APPROVING ALL OPERATING AND CAPITAL BUDGETS, CONTROLLING THE INVESTMENT OF FUNDS, LOCATION OF SERVICES, AGREEMENTS AND TRANSACTIONS, AFFILIATIONS, CHANGES, AMENDMENTS, OR RESTATEMENTS OF CERTIFICATES OF INCORPORATION AND BYLAWS, ADOPTING A SYSTEM-WIDE VISION AND STRATEGIC PLANS, AND APPROVING DEBT BORROWINGS.

FORM 990, PART VI, SECTION B, LINE 11: PRIOR TO FILING THE 990, THE FOLLOWING STEPS ARE TAKEN: 1) THE ACCOUNTING MANAGER, TOGETHER WITH OTHER

Name of the organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

MEMBERS OF THE FINANCE DEPARTMENT, CONDUCT A REVIEW OF THE 990 ALONG WITH A REVIEW AND RECONCILIATION OF THE 990 TO THE AUDITED FINANCIAL STATEMENTS; 2) THE ACCOUNTING MANAGER CONDUCTS AN EXTENSIVE REVIEW AND DISCUSSION OF THE 990 WITH THE CPA FIRM THAT PREPARES THE RETURN; 3) AN ELECTRONIC COPY OF THE 990 IS MADE AVAILABLE TO THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES (THE GOVERNING BOARD), AND SENIOR MANAGEMENT OF THE ORGANIZATION, FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C: ANNUALLY, THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT PROVIDES TO OFFICERS, DIRECTORS, OR TRUSTEES AND KEY EMPLOYEES THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND DISCLOSURE STATEMENT. EACH INDIVIDUAL IS REQUIRED TO RETURN TO THE DEPARTMENT A SIGNED DOCUMENT, ACKNOWLEDGING RECEIPT OF THE POLICY AND DISCLOSURE STATEMENT AND DISCLOSE ANY INTERESTS THAT COULD GIVE RISE TO CONFLICTS. A SUMMARY OF THE DISCLOSURES IS SHARED WITH THE CHAIRMAN OF THE BOARD OF TRUSTEES AND WITH THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD. INDIVIDUALS WHO ARE IDENTIFIED AS HAVING A CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN THE GOVERNING BODIES' DELIBERATIONS AND DECISIONS RELATED TO THE TRANSACTION. THE RETURNED STATEMENTS ARE RETAINED BY THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT.

FORM 990, PART VI, SECTION B, LINE 15: THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND

Name of the organization: MANCHESTER MEMORIAL HOSPITAL
Employer identification number: 06-0646710

RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS; (4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE INCENTIVE OPPORTUNITY, BENEFITS AND COMPENSATION. THE LAST COMPENSATION REVIEW OCCURRED 12/13/2012.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION, WILL, UPON REQUEST, ALLOW FOR REVIEW OF GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND MOST RECENT ANNUAL AUDITED FINANCIAL STATEMENTS AT AN OFFICE OF THE ORGANIZATION.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN BENEFICIAL INTEREST IN TRUSTS	403,720.
CHANGE IN INTEREST RATE SWAP AGREEMENT	110,862.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	26,481,163.
NET TRANSFER FROM/(TO) AFFILIATES	-3,827,077.
TOTAL TO FORM 990, PART XI, LINE 9	23,168,668.

FORM 990, PART XI, LINE 2C:

THE ECHN AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THERE HAVE BEEN NO CHANGES IN THESE PROCESSES SINCE THE PRIOR YEAR.

SCHEDULE R (Form 990)
Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II Identification of Related Tax-Exempt Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
EASTERN CONNECTICUT HEALTH NETWORK, INC - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	INTEGRATED HEALTH CARE SYSTEM PARENT CO	CONNECTICUT	501(C)3	11C, TYPE III	N/A		X
ROCKVILLE GENERAL HOSPITAL - 06-0653151 31 UNION STREET ROCKVILLE, CT 06066	HOSPITAL	CONNECTICUT	501(C)3	3	ECHN	X	
ECHN COMMUNITY HEALTHCARE FOUNDATION, INC - 22-2546080, 71 HAYNES STREET, MANCHESTER, CT 06040	FUNDRAISING/SUPPORT	CONNECTICUT	501(C)3	7	ECHN	X	
ECHN ELDERCARE SERVICE, INC - 06-1149193 26 SHENIPSIT LAKE ROAD TOLLAND, CT 06084	SKILLED NURSING FACILITY	CONNECTICUT	501(C)3	9	ECHN	X	

Schedule R (Form 990) MANCHESTER MEMORIAL HOSPITAL 06-0646710

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) Section 512(b)(13) controlled organization? No
EASTERN CONNECTICUT MEDICAL PROFESSIONAL FOUNDATION, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	PHYSICIAN SERVICES	CONNECTICUT	501(C)3	3	ECHN	X	
VISITING NURSE & HEATLH SERVICES OF CT, INC. - 06-0646795, 8 KEYNOTE DRIVE, VERNON, CT 06066	HOME HEALTHCARE SERVICES	CONNECTICUT	501(C)3	9	ECHN	X	

Part III **Identification of Related Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
MEDICAL PRACTICE PARTNERS, LLC - 27-1498877, P.O. BOX 3830, VERNON, CT 06066	BILLING AND PRACTICE MANAGEMENT SERVICES	CT	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
ECHN ENTERPRISE, INC. - 22-2546828 71 HAYNES STREET MANCHESTER, CT 06040	REAL ESTATE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A	X	
HAYNES STREET PROPERTY MANAGEMENT, LLC - 22-2546028, 71 HAYNES STREET, MANCHESTER, CT 06040	REAL ESTATE PROPERTY MANAGEMENT	CT	N/A	C CORP	N/A	N/A	N/A	X	
ECHN CORPORATE SERVICES - 27-1596320 71 HAYNES STREET MANCHESTER, CT 06040	BILLING AND OTHER PRACTICE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A	X	
CONNECTICUT HEALTHCARE INSURANCE COMPANY - 98-0623043, PO BOX 1109, GRAND CAYMAN, CAYMAN ISLANDS	CAPTIVE INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A	X	

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35b, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	1a		X
b Gift, grant, or capital contribution to related organization(s)	1b	X	
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	X	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o		X
p Reimbursement paid to related organization(s) for expenses	1p		X
q Reimbursement paid by related organization(s) for expenses	1q	X	
r Other transfer of cash or property to related organization(s)	1r	X	
s Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	CONNECTICUT HEALTHCARE INSURANCE COMPANY	B	5,373,092.	CASH TRANSFER
(2)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	J	172,255.	MARKET VALUE
(3)	HAYNES STREET PROPERTY MANAGEMENT	K	169,074.	MARKET VALUE
(4)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	K	102,142.	MARKET VALUE
(5)	EASTERN CT HEALTH NETWORK	L	71,399.	COST
(6)	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	289,165.	COST

Schedule R (Form 990) MANCHESTER MEMORIAL HOSPITAL 06-0646710

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) EASTERN CT HEALTH NETWORK	M	21,156,078.	COST
(8) ECHN ELDERCARE SERVICES, INC.	Q	2,067,558.	CASH TRANSFER
(9) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	Q	1,615,030.	CASH TRANSFER
(10) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	4,282,611.	CASH TRANSFER
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

Part VI Unrelated Organizations Taxable as a Partnership (Complete if the organization answered "Yes" to Form 990, Part IV, line 37.)

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AUGUST 15, 2014
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

Form **990-T**
Department of the Treasury
Internal Revenue Service

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2012 or other tax year beginning OCT 1, 2012 , and ending SEP 30, 2013

OMB No. 1545-0687
2012
Open to Public Inspection for 501(c)(3) Organizations Only

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

C Book value of all assets at end of year
174154774.

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
MANCHESTER MEMORIAL HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
71 HAYNES STREET

City or town, state, and ZIP code
MANCHESTER, CT 06040

D Employer identification number (Employees' trust, see instructions.)
06-0646710

E Unrelated business activity codes (See instructions)
621500

F Group exemption number (see instructions) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ NON-HOSPITAL LABORATORY SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 2

J The books are in care of ▶ NICHOLAS JAMIESON Telephone number ▶ 860-646-1222

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 6,124,638. b Less returns and allowances 5,213,651. c Balance ▶	1c	910,987.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	910,987.		910,987.
4a	Capital gain net income (attach Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5			
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (see instructions; attach statement)	12			
13	**Total.** Combine lines 3 through 12	13	910,987.		910,987.

Part II Deductions Not Taken Elsewhere (see instructions for limitations on deductions)

(except for contributions, deductions must be directly connected with the unrelated business income)

14	Compensation of officers, directors, and trustees (Schedule K)			14	
15	Salaries and wages			15	399,937.
16	Repairs and maintenance			16	
17	Bad debts			17	
18	Interest (attach statement)			18	
19	Taxes and licenses			19	
20	Charitable contributions (see instructions for limitation rules)			20	
21	Depreciation (attach Form 4562)	21			
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach statement) SEE STATEMENT 1			28	623,491.
29	**Total deductions.** Add lines 14 through 28			29	1,023,428.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-112,441.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3			31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	-112,441.
33	Specific deduction (generally $1,000, but see instructions for exceptions)			33	
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			34	-112,441.

Part III Tax Computation

35	**Organizations taxable as corporations** (see instructions for tax computation). Controlled group members (sections 1561 and 1563) check here ▶ ☐ **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ **(2)** Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts taxable at trust rates** (see instructions for tax computation). Income tax on the amount on line 34 from: ☐ Tax rate schedule or ☐ Schedule D (Form 1041) ▶	36	
37	**Proxy tax** (see instructions) ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Other (attach statement)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44 a	Payments: A 2011 overpayment credited to 2012	44a			
b	2012 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: ☐ Form 2439 ☐ Form 4136 ☐ Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2013 estimated tax** ▶ **Refunded** ▶			49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
1	At any time during the 2012 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "Yes," the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (att. statement)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach statement)	4b					X
5	**Total.** Add lines 1 through 4b	5					

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Signature of officer | Date | ▶ CHIEF FINANCIAL OFFICER Title

May the IRS discuss this return with the preparer shown below (see instructions)? ☒ Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
BETH A. THURZ	BETH A. THURZ	08/14/14		P00346435

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP — Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 — Phone no. 860-678-9200

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach statement)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

	1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach statement)	(b) Other deductions (attach statement)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach statement)	5. Average adjusted basis of or allocable to debt-financed property (attach statement)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

	1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)						
(2)						
(3)						
(4)						

Nonexempt Controlled Organizations

	7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)					
(2)					
(3)					
(4)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals ▶	Enter here and on page 1, Part I, line 9, column (A). 0.			Enter here and on page 1, Part I, line 9, column (B). 0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals ▶	Enter here and on page 1, Part I, line 10, col. (A). 0.	Enter here and on page 1, Part I, line 10, col. (B). 0.				Enter here and on page 1, Part II, line 26. 0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
Totals, Part II (lines 1-5) ▶	Enter here and on page 1, Part I, line 11, col. (A). 0.	Enter here and on page 1, Part I, line 11, col. (B). 0.				Enter here and on page 1, Part II, line 27. 0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

MANCHESTER MEMORIAL HOSPITAL 06-0646710

FORM 990-T OTHER DEDUCTIONS STATEMENT 1

DESCRIPTION	AMOUNT
OUTSIDE LABS	198,662.
RED CROSS CHARGES	11.
SUPPLIES	327,746.
OTHER	97,072.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	623,491.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 2

CORPORATION'S NAME	IDENTIFYING NO
EASTERN CONNECTICUT HEALTH NETWORK, INC.	22-2546079

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/04	261,338.	56,898.	204,440.	204,440.
09/30/05	43,130.	0.	43,130.	43,130.
09/30/06	151,249.	0.	151,249.	151,249.
09/30/07	161,951.	0.	161,951.	161,951.
09/30/12	54,809.	0.	54,809.	54,809.
NOL CARRYOVER AVAILABLE THIS YEAR			615,579.	615,579.

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box ..... ▶ [X]

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions	Employer identification number (EIN) or
	MANCHESTER MEMORIAL HOSPITAL	06-0646710
	Number, street, and room or suite no. If a P.O. box, see instructions. 71 HAYNES STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. MANCHESTER, CT 06040	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ▶ NICHOLAS JAMIESON
  71 HAYNES STREET - MANCHESTER, CT 06040
  Telephone No. ▶ 860-646-1222 FAX No. ▶
- If the organization does not have an office or place of business in the United States, check this box ..... ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐. If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until AUGUST 15, 2014.

5 For calendar year _____, or other tax year beginning OCT 1, 2012, and ending SEP 30, 2013.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return
☐ Change in accounting period

7 State in detail why you need the extension
ADDITIONAL TIME IS NEEDED TO PREPARE A COMPLETE AND ACCURATE RETURN AND TO ALLOW ADEQUATE TIME FOR THE BOARD TO REVIEW PRIOR TO FILING.

8a	If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ Title ▶ CHIEF FINANCIAL OFFICER Date ▶

223842
01-21-13

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2012, or fiscal year beginning OCT 1 , 2012, and ending SEP 30 , 20 13

▶ **Do not send to the IRS. Keep for your records.**

OMB No. 1545-1878

2012

Name of exempt organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Name and title of officer

MICHAEL D. VEILLETTE
CHIEF FINANCIAL OFFICER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a	Form 990 check here ▶ [X]	**b Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	1b 188010793
2a	Form 990-EZ check here ▶ [ ]	**b Total revenue,** if any (Form 990-EZ, line 9)	2b
3a	Form 1120-POL check here ▶ [ ]	**b Total tax** (Form 1120-POL, line 22)	3b
4a	Form 990-PF check here ▶ [ ]	**b Tax based on investment income** (Form 990-PF, Part VI, line 5)	4b
5a	Form 8868 check here ▶ [ ]	**b Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	5b

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize SASLOW LUFKIN & BUGGY, LLP to enter my PIN [redacted]
ERO firm name
Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. [redacted]
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ 08/14/14

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	AUGUST 15, 2014
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 01/13)

Form CT-990T
Connecticut Unrelated Business Income Tax Return

2012

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 , 2012, and Ending ▶ SEPTEMBER 30, 2013

Taxpayer (Please type or print)	Organization name (please type or print)	CT Tax Registration Number
	MANCHESTER MEMORIAL HOSPITAL	6279384-000
	Address number and street PO Box	DRS use only
	71 HAYNES STREET	- - 20
	City or town State ZIP code	Federal Employer ID Number (FEIN)
	MANCHESTER, CT 06040	06-0646710

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) Return status: ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NON-HOSPITAL LABORATORY SERVICES
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut: _____

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2012 federal Form 990-T, Part II, Line 34	1	-112,441	00
2. Federal net operating loss deduction from 2012 federal Form 990-T, Part II, Line 31	2		00
3. Federal deduction for Connecticut tax on unrelated business taxable income	3		00
4. **Total:** Add Lines 1, 2, and 3	4	-112,441	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4	6	-112,441	00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3**	1	-112,441	00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places	2		
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2	3	-112,441	00
4. Operating loss carryover from *Schedule B*, Line 13 on page 2	4		00
5. Income subject to tax: Subtract Line 4 from Line 3	5	-112,441	00
6. **Tax:** Multiply Line 5 by 7.5% (.075)	6		00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions	1		00
2. *Reserved for future use*	2		
3. Total Tax: Enter the amount from Line 1	3		00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1**	4		00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."	5	0	00
6a. Paid with application for extension from **Form CT-990T EXT**	6a		00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC, & ESD**	6b		00
6c. Overpayment from prior year	6c		00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	7		00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ CT-1120I Interest ▶ (8c) _____	8		00
9. Amount to be credited to 2013 estimated tax ▶ (9a) Refunded ▶ (9b)	9		00

For faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8	10	0	00

Visit the DRS website at www.ct.gov/TSC to pay electronically. www.ct.gov/DRS TSC Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Signature of officer or fiduciary	Date	May DRS contact the preparer shown below about this return? See instructions.
Keep a copy of this return for your records.	Title: CHIEF FINANCIAL OFFICER	Telephone number: 860-646-1222	☒ Yes ☐ No
	Officer's email address		
	Paid preparer's signature	Date: 08/14/14	Preparer's SSN or PTIN: [redacted]
	Firm's name and address: SASLOW LUFKIN & BUGGY, LLP SIMSBURY, CT 06089	FEIN: 06-1533253	Telephone number: 860-678-9200

1019

241901 01-22-13

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut		Column B Everywhere		Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories		00		00	
	(b) Tangible property		00		00	
	(c) Real property		00		00	
	(d) Capitalized rent		00		00	
	1. Total		00		00	
Receipts	2. (a) Sales of tangibles		00		00	
	(b) Services		00		00	
	(c) Rentals		00		00	
	(d) Other		00		00	
	2. Total		00		00	
Wages, salaries, and other compensation	**3. Total**		00		00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.					
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.					

Schedule B - Connecticut Apportioned Operating Loss Carryover

1. 2000 Connecticut net operating loss available for use in 2012	1.		00
2. 2001 Connecticut net operating loss available for use in 2012	2.		00
3. 2002 Connecticut net operating loss available for use in 2012	3.		00
4. 2003 Connecticut net operating loss available for use in 2012	4.	204,440	00
5. 2004 Connecticut net operating loss available for use in 2012	5.	43,130	00
6. 2005 Connecticut net operating loss available for use in 2012	6.	151,249	00
7. 2006 Connecticut net operating loss available for use in 2012	7.	161,951	00
8. 2007 Connecticut net operating loss available for use in 2012	8.		00
9. 2008 Connecticut net operating loss available for use in 2012	9.		00
10. 2009 Connecticut net operating loss available for use in 2012	10.		00
11. 2010 Connecticut net operating loss available for use in 2012	11.		00
12. 2011 Connecticut net operating loss available for use in 2012	12.	53,809	00
13. **Total:** Add Lines 1 through 12. Enter here and on *Computation of Tax*, Line 4	13.	614,579	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.	-112,441	00
2. Add back specific deduction from 2012 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.	-112,441	00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2012 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.	-112,441	00

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 5.x products, uncheck the "Shrink oversized pages to paper size" and uncheck the "Expand small pages to paper size" options, in the Adobe "Print" dialog. When using Acrobat 6.x and later products versions, select "None" in the "Page Scaling" selection box in the Adobe "Print" dialog.

CLIENT'S COPY

UNRELATED BUSINESS INCOME

CARRYOVER DATA TO 2013

Name	Employer Identification Number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	192,929.
FEDERAL AMT NET OPERATING LOSS	186,998.

219341
10-23-12

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	ROCKVILLE GENERAL HOSPITAL 31 UNION STREET ROCKVILLE, CT 06066
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 15, 2014.

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2012

Open to Public Inspection

A For the 2012 calendar year, or tax year beginning OCT 1, 2012 and ending SEP 30, 2013

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
ROCKVILLE GENERAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) 31 UNION STREET

Room/suite

City, town, or post office, state, and ZIP code ROCKVILLE, CT 06066

F Name and address of principal officer: PETER J. KARL
SAME AS C ABOVE

D Employer identification number
06-0653151

E Telephone number (860)646-1222

G Gross receipts $ 75,427,241.

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ECHN.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1921 M State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: ROCKVILLE GENERAL HOSPITAL IS A 102 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	5	637
6	Total number of volunteers (estimate if necessary)	6	151
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	775,587.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	663,448.	522,104.
9	Program service revenue (Part VIII, line 2g)	73,307,595.	71,750,291.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	495,855.	2,355,445.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	83,143.	260,020.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	74,550,041.	74,887,860.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	40,311,117.	41,534,240.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	33,696,814.	30,758,310.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	74,007,931.	72,292,550.
19	Revenue less expenses. Subtract line 18 from line 12	542,110.	2,595,310.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	79,868,772.	76,543,854.
21	Total liabilities (Part X, line 26)	58,553,761.	45,491,391.
22	Net assets or fund balances. Subtract line 21 from line 20	21,315,011.	31,052,463.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer Date

▶ MICHAEL D. VEILLETTE, CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
BETH A. THURZ	BETH A. THURZ	08/14/14		[redacted]

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 Phone no. 860-678-9200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III X

1 Briefly describe the organization's mission:
ROCKVILLE GENERAL HOSPITAL IS A 102 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 13,904,461. including grants of $) (Revenue $ 6,657,104.)
INPATIENT SERVIES - ROCKVILLE GENERAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 102 BED ACUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 2,567 INPATIENTS TREATED IN FISCAL YEAR 2013. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses $ 6,178,521. including grants of $) (Revenue $ 7,191,452.)
RADIOLOGY - A WIDE RANGE OF IMAGING DIAGNOSTIC AND TREATMENT SERVICES ARE OFFERED, INCLUDING X-RAYS, CT SCANS, MRI, PET, ULTRASOUND, NUCLEAR MEDICINE, AND MAMMOGRAPHY.

4c (Code:) (Expenses $ 8,484,552. including grants of $) (Revenue $ 17,800,824.)
EMERGENCY DEPARTMENT - EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.)
(Expenses $ 31,348,800. including grants of $) (Revenue $ 39,325,324.)

4e **Total program service expenses** ▶ 59,916,334.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	X	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highest compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	168		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	637		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶				
	See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response to any question in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year ..... If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a	18		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

NICHOLAS JAMIESON - (860)646-1222

71 HAYNES STREET, MANCHESTER, CT 06040

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response to any question in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL, M.D.	1.00									
CHAIRMAN	4.00	X		X				0.	0.	0.
(2) ROBIN MURDOCK MEGGERS	1.00									
VICE CHAIR	2.00	X		X				0.	0.	0.
(3) MICHELE CONLON, M.D.	1.00									
SECRETARY	2.00	X		X				0.	0.	0.
(4) JOY DORIN	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(5) DAVID GONCI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(6) REBECCA JANENDA	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(7) JOSEPH JEAMEL, JR.	1.00									
TREASURER	2.00	X		X				0.	0.	0.
(8) CLAUDIO MILITE, M.D.	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(9) LENORA WILLIAMS, M.D.	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(10) PETER J. KARL	1.00									
PRESIDENT AND CEO	41.50	X		X				0.	769,136.	113,819.
(11) GORDON BRODIE, M.D.	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(12) ANTHONY DISTEFANO, M.D.	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(13) THOMASINA CLEMONS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(14) MILTON DOREMUS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(15) LOUISE ENGLAND	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(16) DONALD GENOVESI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(17) KATHLEEN A. O'NEILL	1.00									
TRUSTEE	3.00	X						0.	0.	0.

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) KEITH J. WOLF	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(19) KEVIN G. MURPHY	1.00									
EVP, TREASURER	41.50			X				0.	471,431.	66,570.
(20) MICHAEL D. VEILLETTE	1.00									
SVP, CHIEF FINANCIAL OFFICER	41.50			X				0.	355,183.	46,063.
(21) DEBORAH GOGLIETTINO	1.00									
SVP, HUMAN RESOURCES	41.50				X			0.	291,172.	41,750.
(22) DENNIS MCCONVILLE	1.00									
SVP, STRATEGIC PLANNING	41.50				X			0.	261,775.	83,473.
(23) DEBORAH PARKER	1.00									
EVP CHIEF CLINICAL OFFICER	41.50				X			0.	335,989.	52,120.
(24) JOEL REICH, M.D.	1.00									
SVP, MEDICAL AFFAIRS	41.50				X			0.	400,584.	119,117.
(25) CHARLES COVIN	1.00									
VP AND CIO	41.50				X			0.	214,967.	38,484.
(26) LEONA CROSSKEY	1.00									
VP, QUALITY	41.50				X			0.	172,720.	69,166.
1b Sub-total ▶								0.	3,272,957.	630,562.
c Total from continuation sheets to Part VII, Section A ▶								976,280.	648,419.	172,753.
d Total (add lines 1b and 1c) ▶								976,280.	3,921,376.	803,315.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 19

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
CONNECTICUT HOSPITAL ASSOCIATION PO BOX 90, WALLINGFORD, CT 06492	VARIOUS SERVICES	279,508.
GRIFFIN YORK & KRAUSE 121 RIVER FRONT DRIVE, MANCHESTER, NH 03102	ADVERTISING SERVICES	259,588.
NAVIX DIAGNOSTIX INC PO BOX 347203, PITTSBURGH, PA 15251-4203	RADIOLOGY SERVICES	215,363.
ROBINSON & COLE, 280 TRUMBULL STREET, HARTFORD, CT 06103-3597	LEGAL SERVICES	212,726.
CONTINENTAL CONNECTICUT LITHOTRIPSY, LLC 2014 LITHO PLACE, FAYETTEVILLE, NC 28304	LITHOTRIPSY SERVICES	210,438.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 13

SEE PART VII, SECTION A CONTINUATION SHEETS

Form 990 ROCKVILLE GENERAL HOSPITAL 06-0653151

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) ROBERT CARROLL, M.D.	1.00									
MED DIR, EMERGENCY DEPARTMENT	41.50				X			0.	528,665.	28,137.
(28) ELLEN G. NEUHAUS MD	37.50									
MEDICAL DIRECTOR						X		213,280.	0.	61,232.
(29) DAVID NEUHAUS, M.D.	37.50									
MEDICAL DIRECTOR	1.00					X		335,156.	0.	8,613.
(30) SALVATORE NAPOLITANO	37.50									
RN						X		126,506.	0.	3,772.
(31) KATHLEEN RYAN	37.50									
RN						X		147,467.	0.	28,954.
(32) MARY POWERS	37.50									
SVP, PATIENT CARE						X		153,871.	0.	25,943.
(33) KATHLEEN SIMS	1.00									
FORMER VP, OPERATIONS	41.50						X	0.	119,754.	16,102.
Total to Part VII, Section A, line 1c								976,280.	648,419.	172,753.

Part VIII Statement of Revenue

Check if Schedule O contains a response to any question in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	41,762.				
	d Related organizations	1d					
	e Government grants (contributions)	1e	318,367.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	161,975.				
	g Noncash contributions included in lines 1a-1f: $						
	h **Total.** Add lines 1a-1f			522,104.			
Program Service Revenue		Business Code					
	2a PATIENT SERVICE REVENUE	622110		68,910,644.	68,910,644.		
	b OTHER HEALTHCARE REVENUE	621500		2,839,647.	2,064,060.	775,587.	
	c						
	d						
	e						
	f All other program service revenue						
	g **Total.** Add lines 2a-2f			71,750,291.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			566,835.			566,835.
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
		(i) Real	(ii) Personal				
	6a Gross rents	501,597.					
	b Less: rental expenses	475,212.					
	c Rental income or (loss)	26,385.					
	d Net rental income or (loss)			26,385.			26,385.
		(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory	1,788,610.					
	b Less: cost or other basis and sales expenses	0.					
	c Gain or (loss)	1,788,610.					
	d Net gain or (loss)			1,788,610.			1,788,610.
	8a Gross income from fundraising events (not including $ 41,762. of contributions reported on line 1c). See Part IV, line 18	a	18,039.				
	b Less: direct expenses	b	32,632.				
	c Net income or (loss) from fundraising events			-14,593.			-14,593.
	9a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
	10a Gross sales of inventory, less returns and allowances	a	54,003.				
	b Less: cost of goods sold	b	31,537.				
	c Net income or (loss) from sales of inventory			22,466.			22,466.
	Miscellaneous Revenue	Business Code					
	11a CAFETERIA REVENUE	722210		225,762.			225,762.
	b						
	c						
	d All other revenue						
	e **Total.** Add lines 11a-11d			225,762.			
	12 **Total revenue.** See instructions.			74,887,860.	70,974,704.	775,587.	2,615,465.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response to any question in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,211,244.		1,211,244.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	30,298,395.	25,753,636.	4,544,759.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,516,426.	1,288,962.	227,464.	
9 Other employee benefits	6,692,032.	5,688,227.	1,003,805.	
10 Payroll taxes	1,816,143.	1,543,722.	272,421.	
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting	176,920.		176,920.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	3,193,558.	1,916,135.	1,277,423.	
12 Advertising and promotion	61,068.		61,068.	
13 Office expenses	109,882.	54,941.	54,941.	
14 Information technology	116,610.	58,305.	58,305.	
15 Royalties				
16 Occupancy	2,015,591.	1,713,252.	302,339.	
17 Travel	5,616.	4,774.	842.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	7,827.	6,653.	1,174.	
20 Interest	682,298.	682,298.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	3,565,031.	2,139,019.	1,426,012.	
23 Insurance	2,130,392.	1,810,833.	319,559.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	10,354,034.	10,354,034.		
b ECHN ALLOCATION	4,307,291.	3,661,197.	646,094.	
c PHYSICIAN FEES	2,459,157.	2,459,157.		
d DUE DILIGENCE	688,516.		688,516.	
e All other expenses	884,519.	781,189.	103,330.	
25 **Total functional expenses.** Add lines 1 through 24e	72,292,550.	59,916,334.	12,376,216.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response to any question in this Part X ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	1,463,822.	1	1,059,290.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	10,959,584.	4	10,269,970.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	1,519,666.	8	1,467,009.
	9	Prepaid expenses and deferred charges	218,800.	9	276,211.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 85,725,381.			
	b	Less: accumulated depreciation — 10b: 58,070,717.	30,472,773.	10c	27,654,664.
	11	Investments - publicly traded securities	20,261,427.	11	14,693,132.
	12	Investments - other securities. See Part IV, line 11	3,503,488.	12	3,353,476.
	13	Investments - program-related. See Part IV, line 11	6,382,135.	13	6,825,019.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	5,087,077.	15	10,945,083.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	79,868,772.	16	76,543,854.
Liabilities	17	Accounts payable and accrued expenses	5,969,615.	17	6,096,840.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	24,199,518.	20	23,587,019.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties	1,466,237.	23	802,316.
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	26,918,391.	25	15,005,216.
	26	**Total liabilities.** Add lines 17 through 25	58,553,761.	26	45,491,391.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	17,066,097.	27	26,773,989.
	28	Temporarily restricted net assets	615,748.	28	561,463.
	29	Permanently restricted net assets	3,633,166.	29	3,717,011.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	21,315,011.	33	31,052,463.
	34	Total liabilities and net assets/fund balances	79,868,772.	34	76,543,854.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	74,887,860.
2	Total expenses (must equal Part IX, column (A), line 25)	2	72,292,550.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,595,310.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	21,315,011.
5	Net unrealized gains (losses) on investments	5	744,254.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	6,397,888.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	31,052,463.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
	If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☒ Both consolidated and separate basis			
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I b ☐ Type II c ☐ Type III - Functionally integrated d ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii)	A family member of a person described in (i) above?	11g(ii)	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) ▶ 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)) ▶ 14 %

15 Public support percentage from 2011 Schedule A, Part II, line 14 ▶ 15 %

16a **33 1/3% support test - 2012.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2011.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2012** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2011** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2011.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.

OMB No. 1545-0047

2012

Name of the organization

ROCKVILLE GENERAL HOSPITAL

Employer identification number

06-0653151

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on Part I, line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	WILLIAM E. BARTON TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 71,868.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	ROCKVILLE GENERAL HOSPITAL AUXILIARY 31 UNION STREET VERNON, CT 06066-3160	$ 40,950.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3	ESTATE OF EVELYN A HALLCHER C/O MALCOLM F. BARLOW, ESQ. 172 EAST CENTER STREET MANCHESTER, CT 06040	$ 25,825.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4	LAURENCE M. DILLON TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 17,037.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
5	ESTATE OF HAZEL S. CUTTA C/O ATTY BRENDA A. DRAGHI PO BOX 90 ELLINGTON, CT 06029	$ 16,779.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
6	MOXON M.E. & D.M. YOST MEMORIAL TRUST 185 ASYLUM STREET HARTFORD, CT 06013	$ 9,218.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	ROCKVILLE BANK FOUNDATION, INC. 1645 ELLINGTON ROAD SOUTH WINDSOR, CT 06074-2764	$ 7,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
8	AMBULANCE SERVICE OF MANCHESTER 275 NEW STATE ROAD PO BOX 300 MANCHESTER, CT 06045-0300	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
9	CT DEPARTMENT OF PUBLIC HEALTH - EARLY DETECTION PROGRAM 410 CAPITAL AVENUE HARTFORD, CT 06134-0308	$ 215,841.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
10	HARTFORD DEPARTMENT OF HEALTH AND HUMAN SERVICES 131 COVENTRY STREET HARTFORD, CT 06112	$ 86,241.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
11	CT DEPARTMENT OF PUBLIC HEALTH - HOSPITAL EMERGENCY PREPAREDNESS 410 CAPITAL AVENUE HARTFORD, CT 06134-0308	$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of $1,000 or less for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.**

OMB No. 1545-0047

2012

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax), or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		15,222.
j Total. Add lines 1c through 1i			15,222.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED THAT FOR ITS FISCAL YEAR THAT $10,709 OF ITS MEMBERSHIP DUES FROM ROCKVILLE GENERAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE TOTAL LOBBYING PORTION FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA) FOR ROCKVILLE GENERAL HOSPITAL WAS $4,513.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	10,707,116.	9,113,580.	9,026,890.	8,595,357.	9,683,898.
b Contributions				8,524.	
c Net investment earnings, gains, and losses	1,197,900.	1,593,536.	86,690.	423,119.	-1,088,541.
d Grants or scholarships					
e Other expenditures for facilities and programs	300,000.				
f Administrative expenses				110.	
g End of year balance	11,605,016.	10,707,116.	9,113,580.	9,026,890.	8,595,357.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 85.27 %
b Permanent endowment ▶ 10.79 %
c Temporarily restricted endowment ▶ 3.94 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)	X	
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b	X	

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		644,006.		644,006.
b Buildings		46,940,158.	27,280,521.	19,659,637.
c Leasehold improvements		1,438,080.	492,252.	945,828.
d Equipment		36,139,070.	29,806,694.	6,332,376.
e Other		564,067.	491,250.	72,817.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				27,654,664.

Schedule D (Form 990) 2012

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INTEREST IN NET ASSETS OF		
(2) ECHN COMMUNITY HEALTHCARE		
(3) FOUNDATION, INC.	3,616,191.	END-OF-YEAR MARKET VALUE
(4) INVESTMENTS IN JOINT		
(5) VENTURES	3,208,828.	COST
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	6,825,019.	

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	9,080,600.
(2) OTHER	811,215.
(3) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	1,053,268.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	10,945,083.

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ESTIMATED SELF INSURANCE	
(3) LIABILITIES	2,423,371.
(4) ACCRUED PENSION AND POSTRETIREMENT	
(5) BENEFITS	10,256,944.
(6) CONDITIONAL ASSET RETIREMENT	
(7) OBLIGATION	132,211.
(8) DUE TO AFFILIATED ENTITIES	398,089.
(9) DUE TO THIRD PARTY PAYERS	1,040,198.
(10) OTHER CURRENT LIABILITIES	754,403.
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	15,005,216.

2. FIN 48 (ASC 740) Footnote. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ..... [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	74,988,960.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	176,997.		
e	Add lines 2a through 2d			2e	176,997.
3	Subtract line 2e from line 1			3	74,811,963.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	75,897.		
c	Add lines 4a and 4b			4c	75,897.
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	74,887,860.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	72,330,334.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	64,169.		
e	Add lines 2a through 2d			2e	64,169.
3	Subtract line 2e from line 1			3	72,266,165.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	26,385.		
c	Add lines 4a and 4b			4c	26,385.
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	72,292,550.

Part XIII Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4: THE PRINCIPAL AND INCOME FROM THE UNRESTRICTED ENDOWMENT FUNDS AND THE INCOME FROM THE TERM ENDOWMENTS ARE FOR CAPITAL AND OPERATING NEEDS OF ROCKVILLE GENERAL HOSPITAL. THE INCOME FROM THE PERMANENT ENDOWMENTS AND PRINCIPAL FROM THE TERM ENDOWMENTS ARE FOR THE USE OF ROCKVILLE GENERAL HOSPITAL AS RESTRICTED BY THE DONORS.

PART X, LINE 2: THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES," WHICH PROVIDES

Part XIII Supplemental Information *(continued)*

A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION.

THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2013 AND 2012. AS OF SEPTEMBER 30, 2013 AND 2012, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	31,537.
NET ASSETS RELEASED FROM RESTRICTIONS USED FOR OPERATIONS	112,828.
FUNDRAISING EVENT EXPENSES	32,632.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	176,997.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

CHANGE IN TEMPORARILY RESTRICTED NET ASSETS	49,512.
NET RENTAL INCOME	26,385.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	75,897.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	31,537.
FUNDRAISING EVENT EXPENSES	32,632.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	64,169.

Part XIII Supplemental Information *(continued)*

PART XII, LINE 4B - OTHER ADJUSTMENTS:

NET RENTAL INCOME	26,385.

SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization
ROCKVILLE GENERAL HOSPITAL

Employer identification number
06-0653151

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2 a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Schedule G (Form 990 or 990-EZ) 2012 ROCKVILLE GENERAL HOSPITAL 06-0653151 Page 2

Part II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than $5,000.

		(a) Event #1 GOLF CLASSIC (event type)	(b) Event #2 (event type)	(c) Other events NONE (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	59,801.			59,801.
	2 Less: Contributions	41,762.			41,762.
	3 Gross income (line 1 minus line 2)	18,039.			18,039.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	7,890.			7,890.
	6 Rent/facility costs	9,898.			9,898.
	7 Food and beverages	10,060.			10,060.
	8 Entertainment				
	9 Other direct expenses	4,784.			4,784.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(32,632.)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				-14,593.

Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	13a	%
b An outside facility	13b	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____ .

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $ _____

Part IV **Supplemental Information.** Complete this part to provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
ROCKVILLE GENERAL HOSPITAL

Employer identification number
06-0653151

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [ ] 200% [X] Other 125 %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other _____ %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		X
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		1,145	373,899.	6,316.	367,583.	.51%
b Medicaid (from Worksheet 3, column a)		14,575	10735282.	7229967.	3505315.	4.85%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		15,720	11109181.	7236283.	3872898.	5.36%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	22	42,719	1178605.	0.	1178605.	1.63%
f Health professions education (from Worksheet 5)	9	205	541,612.		541,612.	.75%
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)	1		8,865.		8,865.	.01%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	4	799	18,116.		18,116.	.03%
j **Total.** Other Benefits	36	43,723	1747198.		1747198.	2.42%
k **Total.** Add lines 7d and 7j	36	59,443	12856379.	7236283.	5620096.	7.78%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support		9	915.		915.	.00%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building			112.		112.	.00%
7	Community health improvement advocacy			1,704.		1,704.	.00%
8	Workforce development		48	170.		170.	.00%
9	Other						
10	Total		57	2,901.		2,901.	

Part III Bad Debt, Medicare, & Collection Practices

				Yes	No
Section A. Bad Debt Expense					
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	4,127,214.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3	1,271,767.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				
Section B. Medicare					
5	Enter total revenue received from Medicare (including DSH and IME)	5	21,428,616.		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	23,451,294.		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-2,022,678.		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other				
Section C. Collection Practices					
9a	Did the organization have a written debt collection policy during the tax year?	9a		X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b		X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, and primary website address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 ROCKVILLE GENERAL HOSPITAL 31 UNION STREET VERNON, CT 06066	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group ROCKVILLE GENERAL HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j [ ] Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3 In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	X	
5 Did the hospital facility make its CHNA report widely available to the public?	5	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website			
b [X] Available upon request from the hospital facility			
c [X] Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):			
a [X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b [X] Execution of the implementation strategy			
c [ ] Participation in the development of a community-wide plan			
d [ ] Participation in the execution of a community-wide plan			
e [ ] Inclusion of a community benefit section in operational plans			
f [ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g [X] Prioritization of health needs in its community			
h [X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i [ ] Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)* ROCKVILLE GENERAL HOSPITAL

			Yes	No
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 125 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[X] Medical indigency			
d	[ ] Insurance status			
e	[ ] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[X] Other (describe in Part VI)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Part VI)			
Billing and Collections				
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			

Part V Facility Information *(continued)* ROCKVILLE GENERAL HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☐ Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- d ☐ Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Part VI)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- d ☐ Other (describe in Part VI)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☒ Other (describe in Part VI)

21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI.	21		X
22 During the tax year, did the hospital facility charge any FAP-eligible individuals an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Part VI.	22		X

Part V Facility Information *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

PART II: ROCKVILLE GENERAL HOSPITAL (RGH), AS PART OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. COMMUNITY BUILDING ACTIVITIES INCLUDE SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY BOARD; AND NUMEROUS COMMUNITY COALITIONS THAT ADDRESS ADOLESCENT BEHAVIORAL HEALTH CONCERNS. AS A RESULT OF THESE ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

PART III, LINE 4: THE HOSPITAL PROVIDES FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND

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PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE HOSPITAL OFFERS A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

PART III, LINE 8: THE HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL, REGARDLESS OF THEIR ABILITY TO PAY. CHARITY CARE IS PROVIDED TO THOSE WHO ARE ELIGIBLE BASED ON RGH'S POLICY. THE HOSPITAL ALSO INCURS UNPAID COSTS FOR GOVERNMENT PROGRAMS BECAUSE REIMBURSEMENT IS NOT SUFFICIENT TO COVER COSTS ASSOCIATED WITH MEDICARE AND MEDICAID PATIENTS. THE ORGANIZATION'S MEDICARE COST REPORT WAS USED TO CALCULATE ACTUAL COSTS REPORTED ON PART III, LINE 6. THE ACCESS TO HEALTHCARE BY PATIENTS COVERED BY MEDICARE IS A FUNDAMENTAL PART OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM.

PART III, LINE 9B: INTERNAL AND EXTERNAL COLLECTION POLICIES AND

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PROCEDURES TAKE INTO ACCOUNT THE EXTENT TO WHICH A PATIENT IS QUALIFIED FOR CHARITY CARE OR DISCOUNTS. IN ADDITION, PATIENTS WHO QUALIFY FOR PARTIAL DISCOUNTS ARE REQUIRED TO MAKE A GOOD FAITH EFFORT TO HONOR PAYMENT AGREEMENTS WITH ECHN, INCLUDING PAYMENT PLANS AND DISCOUNTED HOSPITAL BILLS. RGH IS COMMITTED TO WORKING WITH PATIENTS TO RESOLVE THEIR ACCOUNTS, AND AT ITS DISCRETION, MAY PROVIDE EXTENDED PAYMENT PLANS TO ELIGIBLE PATIENTS. RGH WILL NOT PURSUE LEGAL ACTION FOR NON-PAYMENT OF BILLS AGAINST CHARITY CARE PATIENTS WHO HAVE COOPERATED WITH THE HOSPITAL TO RESOLVE THEIR ACCOUNTS AND HAVE DEMONSTRATED THEIR INCOME AND/OR ASSETS ARE INSUFFICIENT TO PAY MEDICAL BILLS.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 3: AS PART OF ITS CHNA, RGH INVITED COMMUNITY AGENCIES AND ORGANIZATIONS THROUGHOUT THE SERVICE AREA, REPRESENTING A VARIETY OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS, TO PARTICIPATE IN AN ONLINE SURVEY, WHICH ASKED QUESTIONS ABOUT WHAT THE INDIVIDUALS PERCEIVED TO BE HEALTHY AND UNHEALTHY ABOUT THE COMMUNITY, WHAT THEIR PERCEPTION IS OF RGH AND THE PROGRAMS AND SERVICES IT OFFERS, AND WHAT RGH CAN DO TO IMPROVE THE HEALTH AND QUALITY OF LIFE IN THE COMMUNITY. AGENCIES AND ORGANIZATIONS RESPONDING TO THE SURVEY INCLUDED THE DEPARTMENT OF PUBLIC HEALTH WIC PROGRAM, COMMUNITY CHILD GUIDANCE CLINIC, VERNON YOUTH SERVICES BUREAU, TOWN OF ELLINGTON HUMAN SERVICES, TOWN OF MANCHESTER HEALTH DEPARTMENT, TOWN OF ANDOVER ELDER SERVICES, MAPLE STREET SCHOOL IN VERNON, VERNON ADULT EDUCATION, INDIAN VALLEY YMCA, AND MARC, INC.

ROCKVILLE GENERAL HOSPITAL:

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PART V, SECTION B, LINE 4: THE CHNA WAS CONDUCTED BY EASTERN CONNECTICUT HEALTH NETWORK, WHICH INCLUDES MANCHESTER MEMORIAL HOSPITAL AND ROCKVILLE GENERAL HOSPITAL.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 5C: HTTP://WWW.ECHN.ORG/FILES/COMMUNITY-BENEFITS/MMH-AND-RGH-CHNA-2013-FINAL-REPORT.ASPX

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 7: AFTER REVIEWING THE CHNA DATA, THE OVERSIGHT COMMITTEE IDENTIFIED EIGHT HEALTH AREAS OF NEED (HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE, ARTHRITIS INCIDENCE, ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING), HOWEVER IT WAS DETERMINED THAT ALL NEEDS COULD NOT BE ADDRESSED BASED ON THE HOSPITAL'S ABILITY TO IMPACT THE NEEDS AND THE AVAILABILITY OF RESOURCES THAT EXIST TO ADDRESS THEM. THE FOLLOWING HEALTH NEEDS WERE IDENTIFIED AS THE HIGHEST PRIORITY: HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE AND ARTHRITIS INCIDENCE.

THE COMMUNITY HEALTH NEEDS ASSESSMENT AND THE STRATEGIES TO ADDRESS THE PRIORITY NEEDS IDENTIFIED (IMPLEMENTATION PLAN) WERE REVIEWED AND APPROVED BY THE ECHN STRATEGIC PLANNING COMMITTEE ON AUGUST 21, 2013. THE ECHN BOARD OF TRUSTEES REVIEWED AND APPROVED THE CHNA AND IMPLEMENTATION PLAN ON SEPTEMBER 25, 2013.

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ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 11: FAMILY SIZE IS USED WITH INCOME LEVEL.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 20D: CHARGES ARE UNIFORMLY SET FOR ALL PATIENTS REGARDLESS OF PAYOR AND CHARITY CARE DISCOUNT IS APPLIED BASED ON INCOME.

PART VI, LINE 2: IN 2013, RGH COLLABORATED WITH MANCHESTER MEMORIAL HOSPITAL, ALSO AN AFFILIATE OF ECHN, TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE GOALS OF THE ASSESSMENT WERE: TO IDENTIFY CURRENT AND FUTURE HEALTHCARE NEEDS IN THE COMMUNITY AND TO IMPROVE AND STRENGTHEN PROGRAMS AND SERVICES PROVIDED TO ADDRESS THEM.

THE CHNA PROCESS WAS LED BY AN OVERSIGHT COMMITTEE THAT INCLUDED MEMBERS OF THE ORGANIZATION WITH ESTABLISHED RELATIONSHIPS WITH COMMUNITY GROUPS AND AGENCIES. DATA COLLECTED FOR THE CHNA INCLUDED: HEALTH, SOCIAL, AND DEMOGRAPHIC DATA SPECIFIC TO RGH'S SERVICE AREA OBTAINED FROM LOCAL PUBLIC HEALTH AGENCIES, NATIONAL HEALTH ASSOCIATIONS AND OTHER DATA SOURCES; HEALTH BEHAVIOR INFORMATION COLLECTED FROM 1,047 RESIDENTS WHO RESPONDED TO A COMMUNITY SURVEY; INPUT FROM 12 COMMUNITY STAKEHOLDERS FROM LOCAL ORGANIZATIONS INVESTED IN THE HEALTH OF UNDERSERVED POPULATIONS.

ONCE ALL DATA WAS COLLECTED AND ANALYZED, THE OVERSIGHT COMMITTEE IDENTIFIED AND PRIORITIZED THE SERVICE AREA'S KEY HEALTH NEEDS AND DEVELOPED AN IMPLEMENTATION STRATEGY TO RESPOND TO THE NEEDS.

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PART VI, LINE 3: THE HOSPITAL COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE THROUGH NOTICES POSTED IN PUBLIC AREAS AROUND THE HOSPITAL, ON THE PATIENT BILLS, ON OUR WEBSITE, AND SELECTED PRE-SCHEDULED SERVICES TO ENSURE THAT THE FINANCIAL CAPACITY OF PEOPLE WHO NEED HEALTHCARE SERVICES DOES NOT PREVENT THEM FROM SEEKING OR RECEIVING CARE.

PART VI, LINE 4: ROCKVILLE GENERAL HOSPITAL, PART OF EASTERN CONNECTICUT HEALTH NETWORK, SERVES A 19-TOWN PRIMARY AND SECONDARY SERVICE AREA LOCATED EAST OF THE CONNECTICUT RIVER IN NORTHERN CONNECTICUT WITH MUNICIPALITIES IN HARTFORD, TOLLAND AND WINDHAM COUNTIES. THE PRIMARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO 20 PERCENT AND INCLUDES THE TOWNS OF MANCHESTER, SOUTH WINDSOR, BOLTON, COVENTRY, ANDOVER, ELLINGTON, TOLLAND, VERNON/ROCKVILLE AND WILLINGTON. THE SECONDARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO FIVE PERCENT AND LESS THAN 20 PERCENT AND INCLUDES THE TOWNS OF ASHFORD, SOMERS, STAFFORD, UNION, EAST HARTFORD, EAST WINDSOR, GLASTONBURY, HEBRON, COLUMBIA AND MANSFIELD.

BASED ON DATA COLLECTED IN 2013, THE POPULATION OF THE ENTIRE SERVICE AREA IS 341,000; 49% MALE, 51% FEMALE. THE MEDIAN AGE OF RESIDENTS IS 39.5 YEARS WITH 33.3% OF THE POPULATION 50 YEARS OR OLDER. THE RACE OF THE RESIDENTS IS PREDOMINANTLY WHITE (80%) FOLLOWED BY BLACK/AFRICAN AMERICAN (8.3%), OTHER/MULTI-RACE (6.1%) AND ASIAN (5.3%). APPROXIMATELY 91.5% PERCENT OF THE POPULATION HAS A HIGH SCHOOL DEGREE AND 35.6% PERCENT HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME FOR THE SERVICE AREA IS $82,075 PER YEAR. JUST UNDER 8% OF HOUSEHOLDS HAVE ANNUAL INCOME AT THE FEDERAL POVERTY RATE. THE UNEMPLOYMENT RATE IS 7.4% AND THE

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AVERAGE HOUSEHOLD SIZE IS 2.61 PEOPLE.

PART VI, LINE 5: COMMUNITY HEALTH EDUCATION INITIATIVES AND PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE FREE COMMUNITY HEALTH EDUCATIONAL PROGRAMS, EDUCATION IN BETTER BEING (A FREE COMMUNITY WELLNESS MAGAZINE), PARTICIPATION IN COMMUNITY HEALTH FAIRS, NUTRITION COUNSELING SERVICES, INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, THE PROMOTION OF CARDIAC REHABILITATION SERVICES, FREE CANCER SCREENINGS, ONCOLOGY NURSE NAVIGATOR AND SURVIVORSHIP NAVIGATORS SERVICES, ANNUAL CANCER SURVIVORS DAY EVENT, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES AND LECTURE PRESENTATIONS. THE EDUCATION PROGRAMS INCLUDE EDUCATING THE PUBLIC ABOUT MANAGING LIFESTYLE BEHAVIORS THAT IMPACT DIET, BLOOD PRESSURE, CHOLESTEROL, WEIGHT, PHYSICAL ACTIVITY, STRESS, CANCER RISKS, DIABETES AND ARTHRITIS.

FREE HEALTH SCREENINGS INCLUDING DIABETIC FOOT CHECKS, PROSTATE AND SKIN CANCER SCREENINGS, MAMMOGRAMS, BLOOD PRESSURE, BONE DENSITY, GLUCOSE READINGS, INJURY SCREENINGS, VITAL SIGN CHECKS AND MEDICAL EXAMS ARE OFFERED IN THE COMMUNITY, TARGETING UNINSURED/UNDERINSURED POPULATIONS.

HEALTHCARE SUPPORT SERVICES ARE PROVIDED BY THE HOSPITAL TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS IN NEED. EFFORTS INCLUDE FREE TRANSPORTATION TO BEHAVIORAL HEALTH PATIENTS, ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, REFERRALS TO SOCIAL SERVICES AND PHYSICIANS ACCEPTING MEDICAID OR OTHER GOVERNMENT PROGRAMS, AND FREE LIFELINE PERSONAL RESPONSE SYSTEM SERVICE.

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PARTNERING WITH LOCAL EDUCATIONAL INSTITUTIONS, ROCKVILLE GENERAL HOSPITAL PROVIDES A CLINICAL SETTING FOR PHYSICIANS, NURSES, RADIOLOGIC TECHNICIANS, RESPIRATORY TECHNICIANS AND PHYSICAL THERAPISTS AND OTHERS FROM THE UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, UNIVERSITY OF CONNECTICUT, MANCHESTER COMMUNITY COLLEGE, CENTRAL CONNECTICUT STATE UNIVERSITY, CAPITAL COMMUNITY COLLEGE, SPRINGFIELD TECHNICAL COMMUNITY COLLEGE, ST. JOSEPH'S COLLEGE, QUINNIPIAC UNIVERSITY, UNIVERSITY OF HARTFORD, BRANFORD HALL, STONE ACADEMY, BRANDEIS UNIVERSITY, SAWYER SCHOOL AND EASTERN CONNECTICUT STATE UNIVERSITY.

SPECIFIC RESEARCH INITIATIVES CONDUCTED BY THE HOSPITAL INCLUDE MAINTENANCE OF A CANCER REGISTRY DATABASE AND AN INSTITUTIONAL REVIEW COMMITTEE. FINANCIAL AND IN-KIND SERVICES AND GOODS ARE DONATED TO COMMUNITY GROUPS AND OTHER NOT FOR PROFIT ORGANIZATIONS INCLUDING PATIENT MEALS, LOCAL FUNDRAISERS, FACILITY SPACE TO HOST BLOOD DRIVES AND HEALTH SUPPORT GROUPS ORGANIZATIONS' MEETINGS.

PART VI, LINE 6: ROCKVILLE GENERAL HOSPITAL (RGH) IS AN AFFILIATE OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), A HEALTH CARE SYSTEM SERVING 19 TOWNS IN EASTERN CONNECTICUT. THE ECHN NETWORK OF AFFILIATES INCLUDES:

MMH, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC & PULMONARY REHABILITATION, A

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COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, AND THE EASTERN CONNECTICUT CANCER INSTITUTE AT THE JOHN A. DEQUATTRO CANCER CENTER. ROCKVILLE GENERAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 102 BEDS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, CARDIAC & PULMONARY REHABILITATION, PHYSICAL REHABILITATION, HOSPICE CARE, A MATERNITY CARE CENTER FOR UNINSURED WOMEN, OUTPATIENT ADOLESCENT BEHAVIORAL HEALTH SERVICES, AND LABORATORY SERVICES.

WOODLAKE AT TOLLAND IS A SKILLED NURSING & REHABILITATION CENTER, A 130-BEDLONG-TERM SKILLED NURSING CARE AND SHORT-TERM REHABILITATION FACILITY. CUSTOMIZED REHABILITATION TREATMENT SERVICES INCLUDE JOINT REPLACEMENT REHABILITATION, ORTHOPEDIC POST-HOSPITAL CARE, STROKE/NEUROLOGICAL REHAB, POST MEDICAL/SURGICAL RECONDITIONING, AND PERSONALIZED, PROGRESSIVE, AND INTERDISCIPLINARY CARE SERVICES.

EASTERN CONNECTICUT MEDICAL PROFESSIONALS (ECMPF) FOUNDATION, INC., A MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOMERS, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE. GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES. ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR); 2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, AND ECMP PRIMARY CARE, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, AND LABORATORY SERVICES. 2600

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TAMARACK AVENUE INCLUDES THE WOMEN'S CENTER FOR WELLNESS, ECHN BREAST CARE COLLABORATIVE, AND THE OB/GYN GROUP OF EASTERN CONNECTICUT. 2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES, INCLUDING ORTHOPEDIC SURGERY, OTOLARYNGOLOGY (ENT), AND GENERAL SURGERY, CORPCARE, AND SOUTH WINDSOR URGENT CARE. ECHN MANCHESTER MEDICAL OFFICE BUILDINGS: 150 NORTH MAIN STREET OFFERS A VARIETY OF BEHAVIORAL HEALTH SERVICES. VISITING NURSE & HEALTH SERVICES OF CONNECTICUT PROVIDES AT-HOME NURSING CARE AND HOSPICE CARE. ECHN HAS 432 PHYSICIANS (317 ACTIVE, 65 COURTESY, 12 CONSULTING, 38 PART-TIME), 83 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16 SERVICES AS WELL AS 15 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO CARE FOR THE COMMUNITY.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

ADDITIONAL INFORMATION:

THE ROCKVILLE GENERAL HOSPITAL, INC. IS A NOT-FOR-PROFIT 102-BED ACUTE CARE HOSPITAL THAT PROVIDES INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES FOR RESIDENTS OF VERNON-ROCKVILLE, CT AND SURROUNDING TOWNS. THE HOSPITAL IS A SUBSIDIARY OF THE EASTERN CONNECTICUT HEALTH NETWORK, INC., WHICH WAS FORMED IN 1995 BY A MERGER OF MMH CORP. AND ROCKVILLE AREA HEALTH SERVICES, INC. ECHN WAS ORGANIZED TO PROVIDE A BROADER HEALTH CARE SYSTEM FOR THE SURROUNDING COMMUNITIES WITH QUALITY MEDICAL CARE AT A REASONABLE COST AND TO FOSTER AN ENVIRONMENT CONDUCIVE TO HEALTH AND WELL BEING WHETHER IN THE HOME OR IN THE COMMUNITY.

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ROCKVILLE GENERAL HOSPITAL PATIENTS NOT HAVING INSURANCE COVERING EMERGENCY OR OTHER MEDICALLY QUALIFIED CARE (UNINSURED PATIENTS), AS WELL AS UNDERINSURED PATIENTS, SUBJECT TO INCOME LIMITS AND FAMILY SIZE RECEIVE FREE OR DISCOUNTED CARE. ROCKVILLE GENERAL HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. CHARGES FOR CARE PROVIDED TO PATIENTS ARE DETERMINED BY ESTABLISHED RATES, SUBJECT TO POSSIBLE ADJUSTMENTS OR DISCOUNTS FOR LOW INCOME PATIENTS; CONTRACTUAL DISCOUNTS, OR DISCOUNTS FOR PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES. CHARITY CARE FOR FY 2013 WAS $1,271,767 FOR 1,145 APPROVED APPLICANTS.

EXPENSES RELATED TO SERVICES PERFORMED FOR PATIENTS OF ROCKVILLE GENERAL HOSPITAL CONTRIBUTE IMPORTANTLY TO ITS EXEMPT PURPOSE BECAUSE THE EXPENSES ARE INCURRED IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT AND PREVENTION OF DISEASE, AND FOR MEDICAL PURPOSES AFFECTING THE STRUCTURE OR FUNCTION OF THE HUMAN BODY.

ROCKVILLE GENERAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY. TWO THOUSAND FIVE HUNDRED SIXTY-SEVEN (2,567) INPATIENTS WERE CARED FOR IN FY13 REPRESENTING 12,325 PATIENT DAYS. ONE HUNDRED TWENTY-TWO THOUSAND TWO HUNDRED TWENTY-FIVE (122,225) OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 2,567 INPATIENTS WERE 2,006 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	1,341

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MEDICARE MANAGED CARE	366
MEDICAID	292
CHAMPUS	7
TOTAL GOV PATIENTS	2,006
TOTAL NON GOV PATIENTS	561
TOTAL PATIENTS	2,567

INCLUDED IN THE 122,225 OUTPATIENT VISITS WERE 55,990 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	26,910
MEDICARE MANAGED CARE	8,959
MEDICAID	19,539
CHAMPUS	582
TOTAL GOV PATIENTS	55,990
TOTAL NON GOV PATIENTS	66,235
TOTAL OUTPATIENT VISITS	122,225

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 14,575 MEDICAID PATIENTS FOR A NET COMMUNITY BENEFIT AMOUNT OF $3,505,315 AFTER MEDICAID REIMBURSEMENT.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 23.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

ROCKVILLE GENERAL HOSPITAL

Employer identification number

06-0653151

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL	(i)	0.	0.	0.	0.	0.	0.	0.
PRESIDENT AND CEO	(ii)	571,136.	198,000.	0.	90,000.	23,819.	882,955.	0.
(2) KEVIN G. MURPHY	(i)	0.	0.	0.	0.	0.	0.	0.
EVP, TREASURER	(ii)	365,827.	105,604.	0.	42,701.	23,869.	538,001.	0.
(3) MICHAEL D. VEILLETTE	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, CHIEF FINANCIAL OFFICER	(ii)	289,379.	65,804.	0.	25,126.	20,937.	401,246.	0.
(4) DEBORAH GOGLIETTINO	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, HUMAN RESOURCES	(ii)	234,772.	56,400.	0.	25,125.	16,625.	332,922.	0.
(5) DENNIS MCCONVILLE	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, STRATEGIC PLANNING	(ii)	212,785.	48,990.	0.	74,088.	9,385.	345,248.	0.
(6) DEBORAH PARKER	(i)	0.	0.	0.	0.	0.	0.	0.
EVP CHIEF CLINICAL OFFICER	(ii)	263,589.	72,400.	0.	30,000.	22,120.	388,109.	0.
(7) JOEL REICH, M.D.	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, MEDICAL AFFAIRS	(ii)	325,831.	74,753.	0.	103,200.	15,917.	519,701.	0.
(8) CHARLES COVIN	(i)	0.	0.	0.	0.	0.	0.	0.
VP AND CIO	(ii)	198,967.	16,000.	0.	23,238.	15,246.	253,451.	0.
(9) LEONA CROSSKEY	(i)	0.	0.	0.	0.	0.	0.	0.
VP, QUALITY	(ii)	146,452.	26,268.	0.	48,609.	20,557.	241,886.	0.
(10) ROBERT CARROLL, M.D.	(i)	0.	0.	0.	0.	0.	0.	0.
MED DIR, EMERGENCY DEPARTMENT	(ii)	395,608.	133,057.	0.	7,500.	20,637.	556,802.	0.
(11) ELLEN G. NEUHAUS MD	(i)	213,280.	0.	0.	40,476.	20,756.	274,512.	0.
MEDICAL DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) DAVID NEUHAUS, M.D.	(i)	310,156.	25,000.	0.	7,500.	1,113.	343,769.	0.
MEDICAL DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) KATHLEEN RYAN	(i)	147,042.	425.	0.	20,543.	8,411.	176,421.	0.
RN	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) MARY POWERS	(i)	153,621.	250.	0.	18,100.	7,843.	179,814.	0.
SVP, PATIENT CARE	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) KATHLEEN SIMS	(i)	0.	0.	0.	0.	0.	0.	0.
FORMER VP, OPERATIONS	(ii)	88,279.	31,475.	0.	6,042.	10,060.	135,856.	0.
	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 3: THE BOARD OF TRUSTEES (THE "BOARD") APPOINTS AN EXECUTIVE COMPENSATION COMMITTEE (THE "COMMITTEE") AND HAS DELEGATED THE RESPONSIBILITY OF COMPLETING AN ANNUAL MARKET ANALYSIS OF THE CEO'S COMPENSATION AND OTHER SENIOR EXECUTIVES AND COMPLETION OF THE CEO'S ANNUAL PERFORMANCE REVIEW.

THE EVALUATION OF THE CEO IS AN IMPORTANT RESPONSIBILITY OF THE BOARD AND IS CRITICAL TO THE GOVERNANCE RESPONSIBILITIES OF THE BOARD. THE EXECUTIVE COMPENSATION COMMITTEE SOLICITS FEEDBACK ABOUT THE PERFORMANCE OF THE CEO FROM EVERY ACTIVE BOARD MEMBER WHICH WHEN RECEIVED IS ANALYZED AND REVIEWED BY THE MEMBERS OF THE COMMITTEE. THE CEO COMPLETES A SELF-EVALUATION AND AN EVALUATION FOR ALL ELIGIBLE MEMBERS OF THE SENIOR LEADERSHIP TEAM, WHO COMPLETE BOTH A SELF-EVALUATION AND A PEER EVALUATION. THE RESULTS OF THE ASSESSMENTS COMPLETED BY THE MEMBERS OF THE SENIOR LEADERSHIP TEAM ARE REVIEWED BY THE CEO WHO DISCUSSES THE RESULTS WITH THE MEMBERS OF THE COMMITTEE ON AN ANNUAL BASIS.

THE EXECUTIVE COMPENSATION COMMITTEE IN COLLABORATION WITH THE CEO

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

EVALUATES AND APPROVES ORGANIZATIONAL PERFORMANCE OBJECTIVES BOTH ON AN ANNUAL AND LONG TERM BASIS AND FOCUSES ON THOSE GOALS WITH THE GREATEST IMPACT TO THE ORGANIZATION'S STRATEGY AND MISSION. THE COMMITTEE ENSURES AN ANNUAL REVIEW OF THE CEO'S PERFORMANCE IN RELATION TO THESE GOALS; REVIEWS THE TALLY SHEETS TO UNDERSTAND THE ECONOMICS OF THE EMPLOYEE BENEFITS; RETAINS AND ENSURES THE INDEPENDENCE OF ITS EXTERNAL CONSULTANTS AND ADVISORS AND INVOLVES RELEVANT ORGANIZATIONAL RESOURCES AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES.

THE COMMITTEE ENSURES TRANSPARENCY AND DISCLOSURE TO THE BOARD BY PRESENTING THE RESULTS OF THE ANNUAL PERFORMANCE AND MARKET REVIEWS PROVIDING THE BOARD WITH THE OPPORTUNITITY FOR FURTHER INPUT AND CONSIDERATION AND ASKING THAT THE BOARD TAKE ACTION ON THE RECOMMENDATION OF THE COMMITTEE IF THE RECOMMENDATION IS APPROPRIATE. THE BOARD HAS THE OPPORTUNITY TO CHANGE ANY RECOMMENDATIONS OF THE COMMITTEE IF IT SO DESIRES. MEMBERS OF THE BOARD AND OF THE COMMITTEE WHO MAY BE INTERESTED PARTIES ARE ASKED TO RECUSE THEMSELVES FROM ANY REQUIRED VOTES TO AVOID CONFLICTS OF INTEREST. THE COMMITTEE ENSURES THAT THE PROCESS MEETS COMPLIANCE STANDARDS.

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 4B:

PETER KARL - $82,500

KEVIN MURPHY - $35,201

MICHAEL VEILLETTE - $17,626

DEBORAH GOGLIETTINO - $17,625

DEBORAH PARKER - $22,500

DENNIS MCCONVILLE - $15,975

JOEL REICH - $25,500

PART I, QUESTIONS 5A, 5B, 6A AND 6B: THE ECHN EXECUTIVE INCENTIVE COMPENSATION PLAN IS A PLAN THAT HAS BEEN DEVELOPED, REVIEWED AND IS ANNUALLY APPROVED BY MEMBERS OF THE BOARD EXECUTIVE COMPENSATION COMMITTEE WITH CONSULTANT THIRD PARTY OVERSIGHT.

THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL (WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

THE INCENTIVE PROGRAM.

THERE IS NO EXECUTIVE COMPENSATION TIED TO THE REVENUES OF THE REPORTING ORGANIZATION OR OTHER RELATED ENTITIES. THERE IS EXECUTIVE COMPENSATION TIED TO THE NET EARNINGS (INCOME FROM OPERATIONS), AS NOTED IN THE PRIOR PARAGRAPH, HOWEVER IT IS ONE OF FOUR PERFORMANCE LEVERS THAT DETERMINE THE LEVEL OF COMPENSATION. THE AGGREGATE NET EARNINGS OF THE ECHN "SYSTEM" NOT ANY ONE REPORTING ORGANIZATION OR RELATED ENTITIES OF ECHN DETERMINE THIS COMPENSATION. SO TO CONCLUDE, THE ANSWER TO THESE 4 QUESTIONS IS "NO" WITH THE CLARIFICATION THAT IT IS THE PERFORMANCE OF THE ENTIRE SYSTEM AS A WHOLE THAT DETERMINES EXECUTIVE COMPENSATION, NOT ONE REPORTING ORGANIZATION OR A RELATED ENTITY.

MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE - KEY EMPLOYEE NAME

PRESIDENT AND CEO - PETER J. KARL

EVP, TREASURER - KEVIN G. MURPHY

SVP, CHIEF FINANCIAL OFFICER - MICHAEL D. VEILLETTE

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SVP, HUMAN RESOURCES - DEBORAH GOGLIETTINO

SVP, STRATEGIC PLANNING - DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER - DEBORAH PARKER

SVP, MEDICAL AFFAIRS - JOEL REICH, M.D.

VP AND CIO - CHARLES COVIN

VP QUALITY - LEONA CROSSKEY

VP, OPERATIONS - KATHLEEN SIMS

MED. DIR. EMERGENCY DEPARTMENT - ROBERT CARROLL, M.D.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part I Bond Issues SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pooled financing Yes	(i) Pooled financing No
A	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774UAZ8	11/09/05	37579404.	ADVANCE REFUND AND DEFEASE A POR		X		X		X
B	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	NONEAVAIL	05/14/09	15250000.	WOODLAKE EXPANSION, EQUIPM		X		X		X
C	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774U5W1	12/21/10	20145000.	REDEEM PRIOR ISSUE AND FUND IN		X		X		X
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	37,579,404.	15,250,000.	20,145,000.	
4	Gross proceeds in reserve funds	3,556,957.		1,065,002.	
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	32,759,288.	9,966,919.	17,048,821.	
7	Issuance costs from proceeds	632,013.	305,000.	402,900.	
8	Credit enhancement from proceeds	631,146.		92,225.	
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		4,978,081.		
11	Other spent proceeds			1,536,052.	
12	Other unspent proceeds				
13	Year of substantial completion	2006	2009	2011	

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
14	Were the bonds issued as part of a current refunding issue?		X	X		X			
15	Were the bonds issued as part of an advance refunding issue?	X			X		X		
16	Has the final allocation of proceeds been made?	X		X		X			
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X			

Part III Private Business Use

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		

Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	.00 %		.00 %		.00 %		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	.00 %		.00 %		.00 %		%	
6 Total of lines 4 and 5	.00 %		.00 %		.00 %		%	
7 Does the bond issue meet the private security or payment test?	X		X		X			
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X		X		

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T?		X		X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		
b Exception to rebate?		X	X			X		
c No rebate due?	X			X		X		
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X	X		X			
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X			X		
b Name of provider			TD BANK					
c Term of hedge			5.0000000					
d Was the hedge superintegrated?			X					
e Was the hedge terminated?				X				

Part IV Arbitrage *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X			

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES C
(F) DESCRIPTION OF PURPOSE:
ADVANCE REFUND AND DEFEASE A PORTION OF THE SERIES 2000A BONDS (C)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES D
(F) DESCRIPTION OF PURPOSE:
WOODLAKE EXPANSION, EQUIPMENT PURCHASE, REFUNDING PRIOR ISSUE (SER D)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES E
(F) DESCRIPTION OF PURPOSE:
REDEEM PRIOR ISSUE AND FUND INTEREST RATE SWAP TERMINATION PAYMENTS

THE SERIES C BONDS WERE ISSUED AFTER 12/31/02 TO REFUND BONDS ISSUED BEFORE 1/1/03. AS A RESULT, LINES 1 - 9 OF PART III ARE NOT REQUIRED TO BE COMPLETED.

DATE OF LAST ARBITRAGE REBATE CALCULATION:
SERIES C REBATE COMPUTATION WAS DONE 11/9/10.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 (a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	(d) Corrected? No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	(d) From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) No	(h) Approved by board or committee? Yes	(h) No	(i) Written agreement? Yes	(i) No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
DR. DENNIS O'NEILL & DR. M	SEE PART V	210,291.	SEE PART V		X
KATHLEEN O'NEILL	SEE PART V	0.	SEE PART V		X

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DR. DENNIS O'NEILL & DR. MICHELE CONLON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (1)

(C) AMOUNT OF TRANSACTION $ 210,291.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

ECPC CONTRACTS WITH ECHN, INC. TO PROVIDE PATHOLOGY SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING CASHFLOW; PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS. THE 6 OWNERS ARE ALSO WORKING PATHOLOGISTS ALONG WITH TWO PHYSICIAN ASSISTANTS TO MAKE UP THE 8 EMPLOYEES OF THE PRACTICE.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (2)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

(E) SHARING OF ORGANIZATION REVENUES? = NO

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(1) RGH TRUSTEES EACH OWNING MORE THAN 5% OF EASTERN CONNECTICUT PATHOLOGY CONSULTANTS, PC (ECPC) AND TWO OF SIX TOTAL OWNERS OF ECPC.

(2) RGH TRUSTEE AND THE WIFE OF DR. DENNIS O'NEILL, TRUSTEE FOR ALL AFFILIATES, WHO HAS A REPORTABLE TRANSACTION AS NOTED ABOVE.

SCHEDULE L, PART IV, COLUMN (C):

PAYMENT OF $210,291 FROM RGH IS TO ECPC AND NOT DIRECTLY TO ANY OF THE OWNERS OF ECPC.

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
ROCKVILLE GENERAL HOSPITAL

Employer identification number
06-0653151

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

OF THE COMMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

FORM 990, PART III, LINE 4D, OTHER PROGRAM SERVICES:

SEE SCHEDULE H, PART VI

EXPENSES $ 31,348,800. INCLUDING GRANTS OF $ 0. REVENUE $ 39,325,324.

FORM 990, PART VI, SECTION A, LINE 2: BOARD MEMBERS DENNIS O'NEILL AND MICHELE CONLON ARE BUSINESS PARTNERS.

FORM 990, PART VI, SECTION A, LINE 6: ECHN IS THE SOLE MEMBER OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A: ECHN HAS THE AUTHORITY TO ELECT TRUSTEES AND OFFICERS AND APPOINT COMMITTEE MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7B: ECHN HAS VARIOUS POWERS INCLUDING BUT NOT LIMITED TO: APPROVING ALL OPERATING AND CAPITAL BUDGETS, CONTROLLING THE INVESTMENT OF FUNDS, LOCATION OF SERVICES, AGREEMENTS AND TRANSACTIONS, AFFILIATIONS, CHANGES, AMENDMENTS, OR RESTATEMENTS OF CERTIFICATES OF INCORPORATION AND BYLAWS, ADOPTING A SYSTEM-WIDE VISION AND STRATEGIC PLANS, AND APPROVING DEBT BORROWINGS.

FORM 990, PART VI, SECTION B, LINE 11: PRIOR TO FILING THE 990, THE FOLLOWING STEPS ARE TAKEN: 1) THE ACCOUNTING MANAGER, TOGETHER WITH OTHER MEMBERS OF THE FINANCE DEPARTMENT, CONDUCT A REVIEW OF THE 990 ALONG WITH A

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

REVIEW AND RECONCILIATION OF THE 990 TO THE AUDITED FINANCIAL STATEMENTS; 2) THE ACCOUNTING MANAGER CONDUCTS AN EXTENSIVE REVIEW AND DISCUSSION OF THE 990 WITH THE CPA FIRM THAT PREPARES THE RETURN; 3) AN ELECTRONIC COPY OF THE 990 IS MADE AVAILABLE TO THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES (THE GOVERNING BOARD), AND SENIOR MANAGEMENT OF THE ORGANIZATION, FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C: ANNUALLY, THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT PROVIDES TO OFFICERS, DIRECTORS, OR TRUSTEES AND KEY EMPLOYEES THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND DISCLOSURE STATEMENT. EACH INDIVIDUAL IS REQUIRED TO RETURN TO THE DEPARTMENT A SIGNED DOCUMENT, ACKNOWLEDGING RECEIPT OF THE POLICY AND DISCLOSURE STATEMENT AND DISCLOSE ANY INTERESTS THAT COULD GIVE RISE TO CONFLICTS. A SUMMARY OF THE DISCLOSURES IS SHARED WITH THE CHAIRMAN OF THE BOARD OF TRUSTEES AND WITH THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD. INDIVIDUALS WHO ARE IDENTIFIED AS HAVING A CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN THE GOVERNING BODIES' DELIBERATIONS AND DECISIONS RELATED TO THE TRANSACTION. THE RETURNED STATEMENTS ARE RETAINED BY THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT.

FORM 990, PART VI, SECTION B, LINE 15: THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS;

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

(4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE INCENTIVE OPPORTUNITY, BENEFITS, AND COMPENSATION. THE LAST COMPENSATION REVIEW OCCURRED 12/13/2012.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION, WILL, UPON REQUEST, ALLOW FOR REVIEW OF OUR GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND MOST RECENT AUDITED FINANCIAL STATEMENTS AT AN OFFICE OF THE ORGANIZATION.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN BENEFICIAL INTEREST IN TRUSTS	77,870.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	8,152,920.
NET TRANSFER FROM/(TO) AFFILIATES	-1,832,902.
TOTAL TO FORM 990, PART XI, LINE 9	6,397,888.

FORM 990, PART XI, LINE 2C:

THE ECHN AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THERE HAVE BEEN NO CHANGES IN THESE PROCESSES SINCE THE PRIOR YEAR.

SCHEDULE R (Form 990)
Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2012
Open to Public Inspection

Name of the organization
ROCKVILLE GENERAL HOSPITAL

Employer identification number
06-0653151

Part I **Identification of Disregarded Entities** (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II **Identification of Related Tax-Exempt Organizations** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
EASTERN CONNECTICUT HEALTH NETWORK, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	INTERGRATED HEALTHCARE SYSTEM PARENT CO	CONNECTICUT	501(C)3	11C, TYPE III	N/A		X
MANCHESTER MEMORIAL HOSPITAL - 06-0646710 71 HAYNES STREET MANCHESTER, CT 06040	HOSPITAL	CONNECTICUT	501(C)3	3	ECHN	X	
ECHN COMMUNITY HEALTHCARE FOUNDATION, INC. - 22-2546080, 71 HAYNES STREET, MANCHESTER, CT 06040	FUNDRAISING/SUPPORT	CONNECTICUT	501(C)3	7	ECHN	X	
ECHN ELDERCARE SERVICES, INC - 06-1149193 26 SHENIPSIT LAKE ROAD TOLLAND, CT 06084	SKILLED NURSING FACILITY	CONNECTICUT	501(C)3	9	ECHN	X	

Schedule R (Form 990) ROCKVILLE GENERAL HOSPITAL 06-0653151

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) Section 512(b)(13) controlled organization? No
EASTERN CONNECTICUT MEDICAL PROFESSIONAL FOUNDATION, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	PHYSICIAN SERVICES	CONNECTICUT	501(C)3	3	ECHN	X	
VISITING NURSE & HEALTH SERVICES OF CT, INC. - 06-0646795, 8 KEYNOTE DRIVE, VERNON, CT 06066	HOME HEALTHCARE SERVICES	CONNECTICUT	501(C)3	9	ECHN	X	

Part III **Identification of Related Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
MEDICAL PRACTICE PARTNERS - 27-1498877, P.O. BOX 3830, VERNON, CT 06066	BILLING AND PRACTICE MANAGEMENT SERVICES	CT	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" to Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
ECHN ENTERPRISES,INC - 22-2546828 71 HAYNES STREET MANCHESTER, CT 06040	REAL ESTATE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A	X	
HAYNES STREET PROPERTY MANAGEMENT, LLC - 22-2546028, 71 HAYNES STREET, MANCHESTER, CT 06040	REAL ESTATE PROPERTY MANAGEMENT	CT	N/A	C CORP	N/A	N/A	N/A	X	
ECHN CORPORATE SERVICES - 27-1596320 71 HAYNES STREET MANCHESTER, CT 06040	BILLING AND OTHER PRACTICE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A	X	
CONNECTICUT HEALTHCARE INSURANCE COMPANY - 98-0623043, PO BOX 1109, GRAND CAYMAN, CAYMAN ISLANDS	CAPTIVE INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A	X	

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35b, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.		Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	1a		X
b Gift, grant, or capital contribution to related organization(s)	1b		X
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k Lease of facilities, equipment, or other assets from related organization(s)	1k		X
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o		X
p Reimbursement paid to related organization(s) for expenses	1p		X
q Reimbursement paid by related organization(s) for expenses	1q	X	
r Other transfer of cash or property to related organization(s)	1r	X	
s Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	J	109,363.	MARKET VALUE
(2)	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	149,037.	COST
(3)	EASTERN CT HEALTH NETWORK	M	8,418,856.	COST
(4)	ECHN ELDERCARE SERVICES, INC.	Q	2,093,917.	CASH TRANSFER
(5)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	1,835,404.	CASH TRANSFER
(6)				

Part VI Unrelated Organizations Taxable as a Partnership (Complete if the organization answered "Yes" to Form 990, Part IV, line 37.)

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Schedule R (Form 990) 2012

Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	ROCKVILLE GENERAL HOSPITAL 31 UNION STREET ROCKVILLE, CT 06066
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AUGUST 15, 2014
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

Form **990-T**
Department of the Treasury
Internal Revenue Service

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2012 or other tax year beginning OCT 1, 2012 , and ending SEP 30, 2013

OMB No. 1545-0687
2012
Open to Public Inspection for 501(c)(3) Organizations Only

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

C Book value of all assets at end of year
76,543,854.

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
ROCKVILLE GENERAL HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
31 UNION STREET

City or town, state, and ZIP code
ROCKVILLE, CT 06066

D Employer identification number (Employees' trust, see instructions.)
06-0653151

E Unrelated business activity codes (See instructions)
621500

F Group exemption number (see instructions) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ NON-HOSPITAL LABORATORY SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 2

J The books are in care of ▶ NICHOLAS JAMIESON Telephone number ▶ (860)646-1222

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales 2,508,920. b Less returns and allowances 1,733,333. c Balance ▶	1c	775,587.		
2 Cost of goods sold (Schedule A, line 7)	2			
3 Gross profit. Subtract line 2 from line 1c	3	775,587.		775,587.
4a Capital gain net income (attach Schedule D)	4a			
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c Capital loss deduction for trusts	4c			
5 Income (loss) from partnerships and S corporations (attach statement)	5			
6 Rent income (Schedule C)	6			
7 Unrelated debt-financed income (Schedule E)	7			
8 Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10 Exploited exempt activity income (Schedule I)	10			
11 Advertising income (Schedule J)	11			
12 Other income (see instructions; attach statement)	12			
13 **Total.** Combine lines 3 through 12	13	775,587.		775,587.

Part II Deductions Not Taken Elsewhere (see instructions for limitations on deductions)
(except for contributions, deductions must be directly connected with the unrelated business income)

14	Compensation of officers, directors, and trustees (Schedule K)		14	
15	Salaries and wages		15	296,484.
16	Repairs and maintenance		16	
17	Bad debts		17	
18	Interest (attach statement)		18	
19	Taxes and licenses		19	
20	Charitable contributions (see instructions for limitation rules)		20	
21	Depreciation (attach Form 4562)	21		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a	22b	
23	Depletion		23	
24	Contributions to deferred compensation plans		24	
25	Employee benefit programs		25	
26	Excess exempt expenses (Schedule I)		26	
27	Excess readership costs (Schedule J)		27	
28	Other deductions (attach statement) SEE STATEMENT 1		28	345,047.
29	**Total deductions.** Add lines 14 through 28		29	641,531.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13		30	134,056.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3		31	134,056.
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30		32	0.
33	Specific deduction (generally $1,000, but see instructions for exceptions)		33	
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32		34	0.

Part III Tax Computation

35	**Organizations taxable as corporations** (see instructions for tax computation). Controlled group members (sections 1561 and 1563) check here ▶ ☐ **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: (1) Additional 5% tax (not more than $11,750) $ (2) Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts taxable at trust rates** (see instructions for tax computation). Income tax on the amount on line 34 from: ☐ Tax rate schedule or ☐ Schedule D (Form 1041) ▶	36	
37	**Proxy tax** (see instructions) ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Other (attach statement)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2011 overpayment credited to 2012	44a			
b	2012 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: ☐ Form 2439 ☐ Form 4136 ☐ Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2013 estimated tax** ▶ **Refunded** ▶			49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
1	At any time during the 2012 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "Yes," the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (att. statement)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach statement)	4b					X
5	**Total.** Add lines 1 through 4b	5					

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Signature of officer | Date | ▶ CHIEF FINANCIAL OFFICER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
BETH A. THURZ	BETH A. THURZ	08/14/14		P00346435

Firm's name ▶ SASLOW LUFKIN & BUGGY, LLP — Firm's EIN ▶ 06-1533253

Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 — Phone no. 860-678-9200

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach statement)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

	1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach statement)	(b) Other deductions (attach statement)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach statement)	5. Average adjusted basis of or allocable to debt-financed property (attach statement)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

	1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)						
(2)						
(3)						
(4)						

Nonexempt Controlled Organizations

	7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)					
(2)					
(3)					
(4)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

ROCKVILLE GENERAL HOSPITAL 06-0653151

FORM 990-T OTHER DEDUCTIONS STATEMENT 1

DESCRIPTION	AMOUNT
OUTSIDE LABS	83,585.
RED CROSS CHARGES	56,565.
SUPPLIES	196,503.
OTHER	8,394.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	345,047.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 2

CORPORATION'S NAME	IDENTIFYING NO
EASTERN CONNECTICUT HEALTH NETWORK, INC.	22-2546079

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/06	75,187.	55,850.	19,337.	19,337.
09/30/07	194,701.	0.	194,701.	194,701.
09/30/08	98,995.	0.	98,995.	98,995.
09/30/09	13,952.	0.	13,952.	13,952.
NOL CARRYOVER AVAILABLE THIS YEAR			326,985.	326,985.

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box ▶ [X]

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

Part II **Additional (Not Automatic) 3-Month Extension of Time.** Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions	Employer identification number (EIN) or
	ROCKVILLE GENERAL HOSPITAL	06-0653151
	Number, street, and room or suite no. If a P.O. box, see instructions. 31 UNION STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. ROCKVILLE, CT 06066	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ▶ NICHOLAS JAMIESON 71 HAYNES STREET - MANCHESTER, CT 06040
  Telephone No. ▶ (860)646-1222 FAX No. ▶
- If the organization does not have an office or place of business in the United States, check this box ..... ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐. If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until AUGUST 15, 2014.

5 For calendar year _____, or other tax year beginning OCT 1, 2012, and ending SEP 30, 2013.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

7 State in detail why you need the extension
ADDITIONAL TIME IS NEEDED TO PREPARE A COMPLETE AND ACCURATE RETURN AND TO ALLOW ADEQUATE TIME FOR THE BOARD TO REVIEW PRIOR TO FILING.

8a	If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ Title ▶ CHIEF FINANCIAL OFFICER Date ▶

223842
01-21-13

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2012, or fiscal year beginning OCT 1, 2012, and ending SEP 30, 20 13

▶ **Do not send to the IRS. Keep for your records.**

OMB No. 1545-1878

2012

Name of exempt organization

ROCKVILLE GENERAL HOSPITAL

Employer identification number

06-0653151

Name and title of officer

MICHAEL D. VEILLETTE
CHIEF FINANCIAL OFFICER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a, below, and the amount on that line for the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a	Form 990 check here ▶ [X]	b **Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	1b 74887860
2a	Form 990-EZ check here ▶ [ ]	b **Total revenue,** if any (Form 990-EZ, line 9)	2b
3a	Form 1120-POL check here ▶ [ ]	b **Total tax** (Form 1120-POL, line 22)	3b
4a	Form 990-PF check here ▶ [ ]	b **Tax based on investment income** (Form 990-PF, Part VI, line 5)	4b
5a	Form 8868 check here ▶ [ ]	b **Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	5b

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize SASLOW LUFKIN & BUGGY, LLP to enter my PIN [redacted]
ERO firm name
Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. [redacted]
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ 08/14/14

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2013

Prepared for	ROCKVILLE GENERAL HOSPITAL 31 UNION STREET ROCKVILLE, CT 06066
Prepared by	SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	AUGUST 15, 2014
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 01/13)

Form CT-990T
Connecticut Unrelated Business Income Tax Return

2012

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 , 2012, and Ending ▶ SEPTEMBER 30, 2013

Taxpayer (Please type or print)	Organization name (please type or print)	CT Tax Registration Number
	ROCKVILLE GENERAL HOSPITAL	6701775-000
	Address number and street PO Box	DRS use only
	31 UNION STREET	- - 20
	City or town State ZIP code	Federal Employer ID Number (FEIN)
	ROCKVILLE, CT 06066	06-0653151

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) Return status: ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NON-HOSPITAL LABORATORY SERVICES
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut: _____

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. **Federal unrelated business taxable income from 2012 federal Form 990-T, Part II, Line 34** ▶	1		00
2. **Federal net operating loss deduction from 2012 federal Form 990-T, Part II, Line 31** ▶	2	134,056	00
3. Federal deduction for Connecticut tax on unrelated business taxable income ▶	3		00
4. **Total:** Add Lines 1, 2, and 3 ▶	4	134,056	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income ▶	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4 ▶	6	134,056	00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3** ▶	1	134,056	00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places ▶	2		
3. Connecticut unrelated business taxable income: Line 1 or Line 1 multiplied by Line 2 ▶	3	134,056	00
4. Operating loss carryover from *Schedule B*, Line 13 on page 2 ▶	4	134,056	00
5. Income subject to tax: Subtract Line 4 from Line 3 ▶	5		00
6. Tax: Multiply Line 5 by 7.5% (.075) ▶	6		00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions ▶	1		00
2. *Reserved for future use* ▶	2		
3. Total Tax: Enter the amount from Line 1 ▶	3		00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1** ▶	4		00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0." ▶	5	0	00
6a. Paid with application for extension from **Form CT-990T EXT** ▶	6a		00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC, & ESD** ▶	6b		00
6c. Overpayment from prior year ▶	6c		00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c ▶	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5 ▶	7		00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ CT-1120I Interest ▶ (8c) _____	8		00
9. Amount to be credited to 2013 estimated tax ▶ (9a) Refunded ▶ (9b)	9		00

For faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8 ▶	10	0	00

Visit the DRS website at www.ct.gov/TSC to pay electronically. www.ct.gov/DRS TSC Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Signature of officer or fiduciary	Date	May DRS contact the preparer shown below about this return? See instructions.
Keep a copy of this return for your records.	Title: CHIEF FINANCIAL OFFICER	Telephone number: (860)646-1222	☒ Yes ☐ No
	Officer's email address		
	Paid preparer's signature	Date: 08/14/14	Preparer's SSN or PTIN: [redacted]
	Firm's name and address: SASLOW LUFKIN & BUGGY, LLP SIMSBURY, CT 06089	FEIN: 06-1533253	Telephone number: 860-678-9200

1019

241901 01-22-13

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut		Column B Everywhere		Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories		00		00	
	(b) Tangible property		00		00	
	(c) Real property		00		00	
	(d) Capitalized rent		00		00	
	1. Total		00		00	
Receipts	2. (a) Sales of tangibles		00		00	
	(b) Services		00		00	
	(c) Rentals		00		00	
	(d) Other		00		00	
	2. Total		00		00	
Wages, salaries, and other compensation	**3. Total**		00		00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.					
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.					

Schedule B - Connecticut Apportioned Operating Loss Carryover

1. 2000 Connecticut net operating loss available for use in 2012	1.		00
2. 2001 Connecticut net operating loss available for use in 2012	2.		00
3. 2002 Connecticut net operating loss available for use in 2012	3.		00
4. 2003 Connecticut net operating loss available for use in 2012	4.		00
5. 2004 Connecticut net operating loss available for use in 2012	5.		00
6. 2005 Connecticut net operating loss available for use in 2012	6.	19,337	00
7. 2006 Connecticut net operating loss available for use in 2012	7.	193,701	00
8. 2007 Connecticut net operating loss available for use in 2012	8.	97,995	00
9. 2008 Connecticut net operating loss available for use in 2012	9.	12,952	00
10. 2009 Connecticut net operating loss available for use in 2012	10.		00
11. 2010 Connecticut net operating loss available for use in 2012	11.		00
12. 2011 Connecticut net operating loss available for use in 2012	12.		00
13. **Total:** Add Lines 1 through 12. Enter here and on *Computation of Tax*, Line 4	13.	323,985	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.		00
2. Add back specific deduction from 2012 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.		00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2012 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.		00