Saint Mary's Health System, Inc.

&

Tenet Healthcare Corporation's

Certificate of Need Application

September 12, 2014

Saint Mary's Health System, Inc. & Tenet Healthcare Corporation's

CON

Sept. 12, 2014

61764945 v1-WorkSiteUS-080456/0042

BROWNRUDNICK

185 Asylum Street
Hartford
Connecticut
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fax 860.509.6501

ROBERT J. ANTHONY
Counselor at Law
direct dial: 860.509.6517
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ranthony@brownrudnick.com

September 12, 2014

VIA HAND DELIVERY

Office of the Attorney General
Attn.: Gary W. Hawes, Esq., Assistant Attorney General
55 Elm Street
Hartford, CT 06141-0120

Commissioner of Public Health
Attn.: Kevin Hansted, Esq., Staff Attorney
410 Capitol Avenue
Hartford, CT 06134

brownrudnick.com

RE: Saint Mary's Health System, Inc.'s and Tenet Healthcare Corporation's Certificate of Need Application
OHCA Docket No. 14-31927-486
AG Docket No. 14-486-02

Dear Attorneys Hawes and Hansted:

Saint Mary's Health System, Inc. ("Saint Mary's") and Tenet Healthcare Corporation ("Tenet") hereby submit a Certificate of Need Application for approval to transfer substantially all of Saint Mary's assets to a newly-established for-profit affiliate of Tenet (the "Application"). The original and seven (7) copies will be hand delivered to Attorney Hansted's office and four (4) copies will be hand delivered to Attorney Hawes' office. In addition, each office has received three (3) electronic copies of the Application.

Please note that Exhibit O of the Application is being bulk filed and therefore only one hard copy has been provided to Attorney Hawes' office and one hard copy has been provided to Attorney Hansted's office. Exhibit O contains five (5) binders with information on Saint Mary's Hospital Foundation's restricted funds. Exhibit O has also been scanned and is included in the electronic version of the Application – you will see each binder as a separate PDF file after the CON PDF file on the cd. If further hard copies are required, please let me know.

A check in the amount of $500.00, representing the filing fee, was also delivered to Attorney Hansted's office.

If you have any questions or need anything further, please contact me at 860.509.6517. Thank you for your assistance in this matter.

Very truly yours,

BROWN RUDNICK LLP

Robert J. Anthony /cm

Robert J. Anthony

Enclosures

61763141 v1-WorksiteUS-080456/0042

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 I and II.**

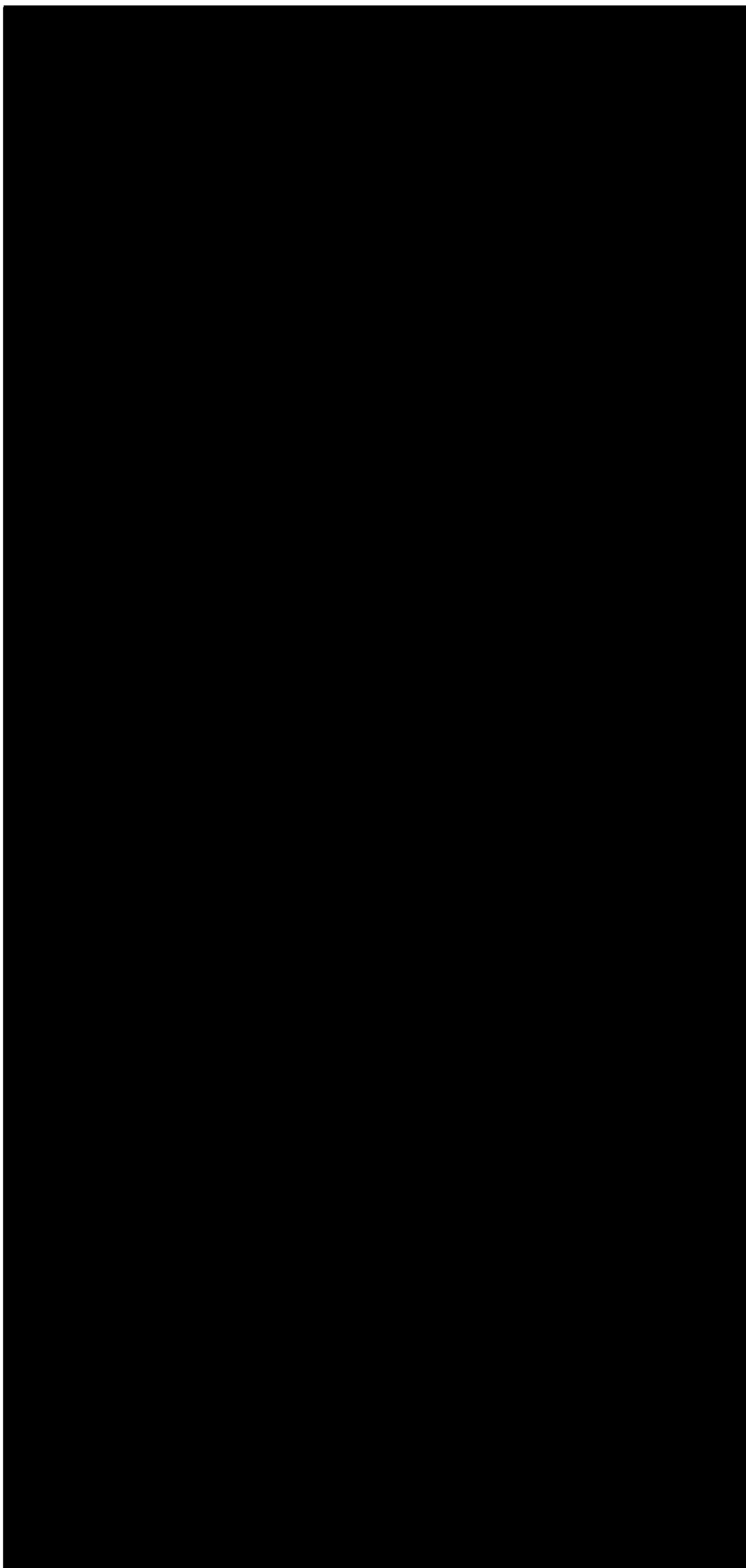
☑ **Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.**

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.**



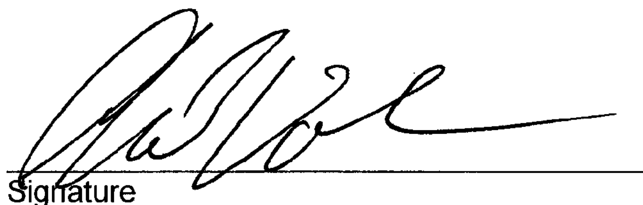
AFFIDAVITS

AFFIDAVIT

Applicant: Saint Mary's Health System, Inc. and Tenet Healthcare Corporation

Project Title: Asset Purchase Agreement of Saint Mary's Health System, Inc., to sell all of its assets, including Saint Mary's Hospital and other related health care entities to a newly-established for-profit entity of Tenet Healthcare Corporation

I, Chad Wable, CEO and President of Saint Mary's Health System, Inc. and Saint Mary's Hospital of Waterbury, CT, being duly sworn, depose and state that the information submitted in this Certificate of Need Application by Saint Mary's Health System, Inc. and Saint Mary's Hospital is accurate and correct to the best of my knowledge.



Signature

9/10/14
Date

Subscribed and sworn to before me on September 10, 2014

Victoria Cipriano

Notary Public~~/Commissioner of Superior Court~~

My commission expires: VICTORIA CIPRIANO
NOTARY PUBLIC
MY COMMISSION EXPIRES FEB. 28, 2017

AFFIDAVIT

Applicant: Saint Mary's Health System, Inc. and Tenet Healthcare Corporation

Project Title: Asset Purchase Agreement of Saint Mary's Health System, Inc., to sell all of its assets, including Saint Mary's Hospital and other related health care entities, to a newly-established for-profit entity of Tenet Healthcare Corporation

I, Harold Pilgrim, Senior Vice President of Development of Tenet Healthcare Corporation being duly sworn, depose and state that the information submitted in this Certificate of Need Application by Tenet Healthcare Corporation is accurate and correct to the best of my knowledge.

Signature ______ 9/10/2014 Date

Subscribed and sworn to before me on 9/10/2014

______

Notary Public/Commissioner of Superior Court

My commission expires: 5/3/2016

ACTIVE/76178.1/KDALEY/4792607v1

Ad #: RA0633386

AFFIDAVIT OF PUBLICATION

Legal Notice
Notice of Public Hearing

Pursuant to Connecticut General Statute 19a-486a, as amended by 2014 Feb. Session P.A. 14-168 (Subst. Senate Bill No. 35, LCO No. 5690), Saint Mary's Health System, Inc. ("Saint Mary's") proposes to sell substantially all of the assets of Saint Mary's to Tenet Healthcare Corporation ("Tenet").

Tenet will pay $150 million dollars for the assets of Saint Mary's and will commit to spend no less than $85 million dollars on capital items and service improvements in the greater Waterbury area. As part of this proposal, Saint Mary's existing debt will be eliminated, and the pension fund will be fully funded to date.

A hearing will be held by Saint Mary's and Tenet on the above proposal at Saint Mary's Hospital at 56 Franklin St., Waterbury on Monday, July 28, 2014 at 5:00 P.M. in the Hospital's auditorium. The public is invited to attend.

RA 7/11,12,13,2014

STATE OF CONNECTICUT
County of New Haven   Waterbury   July 16th 20 14

The subcriber, being duly sworn, deposes and says that he (she) is the bookkeeper
of the **Republican-American** and that the foregoing notice for

ST. MARY'S HOSPITAL

was published in said **Republican-American** in **3** editions of said newspaper issued between **07/11/14** and **07/13/14**

[signature]

SUBSCRIBED AND SWORN BEFORE ME THIS THE 16Th

day of July 20 14

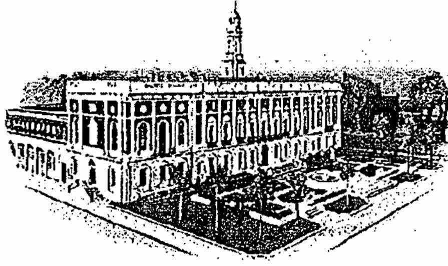
Susan R Hudson

Notary Public

My Commission Expires: 3/31/14

000008

LETTERS OF SUPPORT



OFFICE OF THE MAYOR
THE CITY OF WATERBURY
CONNECTICUT

September 9, 2014

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am writing in support of Saint Mary's application to sell its assets to Tenet Healthcare Corporation. The health care environment is changing rapidly, and stand-alone hospitals are finding it difficult to come up with the resources necessary to offer quality care to all of their patients.

Tenet has made a generous offer to purchase Saint Mary's assets. In other situations where a Catholic hospital has become part of its network, Tenet has allowed the hospital to remain Catholic, and operate under the Ethical and Religious Directives. Further, Tenet has made a commitment to continue to operate Saint Mary's under the "community benefit requirements" issued by the IRS for non-profit hospitals, which means that all Medicare and Medicaid patients will be accepted at Saint Mary's in the future.

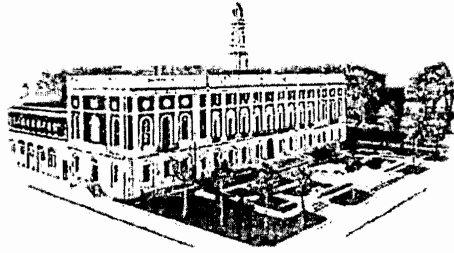
Tenet is a large healthcare provider that owns and operates 79 acute-care hospitals in 14 states. These people are knowledgeable about how to operate hospitals efficiently so that there are resources available to provide the best care possible. The demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on Saint Mary's in the future. A capital partner, like Tenet, will help Saint Mary's continue to provide exceptional care. Tenet has made a commitment to the region and will infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Tenet Healthcare Corporation.

Respectfully submitted,

Neil M. O'Leary, Mayor

235 Grand Street • Waterbury, Connecticut 06702 • (203) 574-6712



DEPARTMENT OF PUBLIC HEALTH
THE CITY OF WATERBURY
CONNECTICUT

September 4, 2014

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

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I strongly recommend that you approve the application submitted by Saint Mary's Health System and Tenet Healthcare Corporation.

Respectfully submitted,

William P. Quinn
Director of Public Health

One Jefferson Square • Waterbury, Connecticut 06706-1102 • (203) 574-6780 • FAX (203) 597-3481

Waterbury Regional Chamber
driving business to business

September 11, 2014

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am writing to express support for the proposed transaction between Saint Mary's Hospital and Tenet Healthcare Corporation.

Saint Mary's plays a major role in the greater Waterbury community. The Waterbury Regional Chamber continually advocates for measures that improve the local quality of life. A strong healthcare system is a key factor in where companies choose to do business. In that regard, St. Mary's provides essential healthcare services to citizens of Waterbury and the surrounding 19 towns. As a safety net provider, its programming ensures that our neediest citizens receive the care they need and deserve.

However, Saint Mary's importance to greater Waterbury extends far beyond that of a provider of healthcare services. As our region's premiere business organization, the Chamber recognizes the essential position Saint Mary's has in the business community. It is one of the top three employers in our region, providing stable, well-paying jobs to nearly 2,000 individuals. The multiplying effect that hospitals have on their local economies is well-documented, with these facilities having an economic impact that extends to all sectors of the economy, including suppliers, service providers, restaurants and hotels. Finally, Saint Mary's provides much-needed leadership and support to many local organizations, including the Chamber.

For all of these reasons, the long term presence of Saint Mary's is essential for a healthy greater Waterbury. Saint Mary's has done well to position itself during very challenging market conditions, and its plan to be acquired by Tenet shows a keen understanding of the future challenges and dynamics within the healthcare sector.

Sincerely,

Lynn Ward
President & CEO
Waterbury Regional Chamber

83 Bank Street • P.O. Box 1469 • Waterbury, CT 06721
Tel: 203.757.0701 • Fax: 203.756.3507 • www.waterburychamber.com

ent Naugatuck Valley
Ear, Nose & Throat Associates LLC

Jerome O. Sugar, MD, FAAOHNS
Raymond E. Winicki, MD, FAAOHNS
Judith S. Lynch, MS, APRN, FAANP

171 Grandview Avenue Suite 201 Waterbury, CT 06708 203.578.4630 *phone* 203.578.4629 *fax* www.naugatuckvalleyent.com *web*

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am writing in support of Saint Mary's application to sell its assets to Tenet Healthcare Corporation. The health care environment is changing rapidly, and stand-alone hospitals are finding it difficult to come up with the resources necessary to offer quality care to all of their patients.

Tenet has made a generous offer to purchase Saint Mary's assets. In other situations where a Catholic hospital has become part of its network, Tenet has allowed the hospital to remain Catholic, and operate under the Ethical and Religious Directives. Further, Tenet has made a commitment to continue to operate Saint Mary's under the "community benefit requirements" issued by the IRS for non-profit hospitals, which means that all Medicare and Medicaid patients will be accepted at Saint Mary's in the future.

Tenet is a large healthcare provider that owns and operates 79 acute-care hospitals in 14 states. These people are knowledgeable about how to operate hospitals efficiently so that there are resources available to provide the best care possible. The demands of the new healthcare laws and the high cost of technology necessary to run a large hospital will put enormous pressures on Saint Mary's in the future. A capital partner, like Tenet, will help Saint Mary's continue to provide exceptional care. Tenet has made a commitment to the region and will infuse time, talent and capital to keep the safety network for health care alive and well in Waterbury.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Tenet Healthcare Corporation.

Respectfully submitted,

Jerome Sugar MD

September 10, 2014

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am writing in support of Saint Mary's application to sell its assets to Tenet Healthcare Corporation. The health care environment is changing rapidly, and stand-alone hospitals are finding it difficult to come up with the resources necessary to offer quality care to all of their patients.

Tenet has made a generous offer to purchase Saint Mary's assets. In other situations where a Catholic hospital has become part of its network, Tenet has allowed the hospital to remain Catholic, and operate under the Ethical and Religious Directives. Further, Tenet has made a commitment to continue to operate Saint Mary's under the "community benefit requirements" issued by the IRS for non-profit hospitals, which means that all Medicare and Medicaid patients will be accepted at Saint Mary's in the future.

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I strongly recommend that you approve the application submitted by Saint Mary's Health System and Tenet Healthcare Corporation.

Respectfully submitted,

Robert Gumbardo, M.D.
Chief of Staff, Saint Mary's Hospital

56 Franklin Street, Waterbury, Connecticut 06706 (203) 709-6000 www.stmh.org
An affiliate of Saint Mary's Health System

September 10, 2014

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am writing in support of Saint Mary's application to sell its assets to Tenet Healthcare Corporation. The health care environment is changing rapidly, and stand-alone hospitals are finding it difficult to come up with the resources necessary to offer quality care to all of their patients.

It is our understanding that Tenet has made a generous offer to purchase Saint Mary's assets. Further, Tenet has made a commitment to continue to operate Saint Mary's under the "community benefit requirements" issued by the IRS for non-profit hospitals, which means that all Medicare and Medicaid patients will be accepted at Saint Mary's in the future.

Saint Mary's Hospital is an asset to the Waterbury community. As a partner with the Hospital in community health initiatives, we know how critical it is for Saint Mary's to continue to serve as a health provider and community partner in local health improvement efforts. It is our hope that a capital partner, like Tenet, will help Saint Mary's continue to provide exceptional care.

I strongly recommend that you approve the application submitted by Saint Mary's Health System and Tenet Healthcare Corporation.

Sincerely,

Paula Van Ness

Paula Van Ness
CEO

43 Field Street · Waterbury, CT 06702 · 203.753.1315 · www.conncf.org

THE HAROLD LEEVER
REGIONAL CANCER CENTER

A Partnership for Excellence
St. Mary's Hospital & Waterbury Hospital

9/8/2014

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

Lisa A. Davis, MBA, BSN, RN
Deputy Commissioner
CT Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS# 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Deputy Commissioner Davis,

I am writing in support of Saint Mary's application to sell its assets to Tenet Healthcare Corporation. As you know healthcare is in the middle of some dramatic changes nationwide and now more than ever it is difficult if not impossible for stand alone hospitals to survive and continue to offer quality care.

Tenet Healthcare has made an appropriate offer to purchase Saint Mary's Hospital assets. They have also promised to allow Saint Mary's Hospital to maintain their Catholic mission and operate under the Ethical and Religious directives that they have been committed to for over 100 years. Further, Tenet has made a commitment to continue to operate Saint Mary's under the "community benefit requirements" issued by the IRS for non-profit hospitals, which means that all Medicare and Medicaid patients will be accepted at Saint Mary's in the future.

Being a part of a large healthcare provider like Tenet will allow Saint Mary's Hospital to continue to operate a quality healthcare organization for its community that would not likely be possible otherwise. Healthcare reform and the high cost of technology necessary to run a large hospital are already putting a great deal of pressure on the Saint Mary's Healthcare network and every other healthcare provider.

The Harold Leever Regional Cancer Center 1075 Chase Parkway Waterbury, CT 06708
203.575.5555 203.575.5592 fax www.leevercancercenter.org

On behalf of The Harold Leever Regional Cancer Center and our Board of Directors, I strongly recommend that you approve the application submitted by Saint Mary's Health System and Tenet Healthcare Corporation.

Respectfully submitted,

Kevin Kniery
Executive Director

CON

Certificate of Need Application

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

Saint Mary's Health System, Inc.:
Chad Wable, President and CEO
Saint Mary's Hospital
56 Franklin Street
Waterbury, CT 06706
Phone: (203) 709-3368
Fax: (203) 709-3066
Email: cwable@stmh.org

Tenet Healthcare Corporation:
Jeffrey Peterson, Senior Counsel
1445 Ross Avenue
Suite 1400
Dallas, Texas 75202
Phone: (469) 893-6104
Fax: (469) 893-7104
Email: jeff.peterson@tenethealth.com

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

INTRODUCTION

This Application is submitted by Saint Mary's Health System, Inc. ("Saint Mary's"), the parent company and sole member of Saint Mary's Hospital, Inc. (the "Hospital") and Tenet Healthcare Corporation ("Tenet") for approval to transfer substantially all of Saint Mary's assets relating to the Hospital and its related health care facilities to a newly-established, for-profit affiliate of Tenet ("Buyer" or "New SM Hospital"). Pursuant to the terms of the proposed Asset Purchase Agreement (*See* Exhibit A), Tenet will pay $150 million for these assets, subject to certain adjustments, including a Net Working Capital Adjustment and reductions for liabilities relating to pension, retiree health, capital leases, and any equity interests that do not transfer. In addition, Tenet will commit to spend no less than $85 million on capital items and service improvements in the greater Waterbury community over seven years.

Proceeds from the transaction will eliminate Saint Mary's debt, including payment or defeasance of its Connecticut Health and Education Facilities Authority ("CHEFA") bond indebtedness and provide a significant cash infusion to support local health needs that will benefit consumers.

The New SM Hospital will retain the Hospital's name and its Catholic identity and continue to adhere to the Ethical and Religious Directives for Catholic Health Care Services (the "Directives"). The New SM Hospital will also continue to operate in accordance with the "community benefit standards" required of tax-exempt hospitals (as set forth in Internal Revenue Service Ruling 69-545), including, without limitation, (i) acceptance of all Medicare and Medicaid patients, (ii) acceptance of all emergency patients without regard to ability to pay, (iii) maintenance of an open medical staff, and (iv) promotion of public health, wellness and welfare in the community through the provision of health care at a reasonable cost. The current charity care and uncompensated care policies of the Hospital will continue to be followed by the New SM Hospital and a local advisory board will be established that will provide input and oversight of the New SM Hospital's operations.

Saint Mary's selected Tenet, a leading, national healthcare services company, as its preferred partner after a thorough and deliberative selection process that lasted more than four years and involved numerous potential suitors, both regionally and nationally. Tenet brings the capital and expertise needed to address the coming changes in the healthcare industry and will continue to maintain high quality healthcare services in an affordable and accessible manner for residents of the greater Waterbury area, as recognized in the "Community Health Needs Assessment Final Summary Report" published by the Greater Waterbury Health Improvement Partnership, dated September 2013. (*See* Exhibit B).

THE PARTIES

Saint Mary's Health System, Inc.

Saint Mary's Health System, Inc. (previously defined as "Saint Mary's") is the parent company and sole member of Saint Mary's Hospital, Inc. (previously defined as the "Hospital"). Saint Mary's and the Hospital are both Connecticut non-profit, 501(c)(3) corporations. Saint Mary's single most important asset is the Hospital, which is an acute care facility with 347 licensed beds and 32 bassinets located in downtown, Waterbury, Connecticut. Built in 1907, the Hospital serves 18 towns within its service area. In addition to the Hospital, Saint Mary's assets/entities include the following:

- Franklin Medical Group, P.C., a physician group of approximately 68 physicians and 19 midlevel providers having 14 office locations in the Greater Waterbury area including:
  1) 133 Scovill St., Waterbury; Specialties: General Dentistry, Dermatology, General Surgery, Infectious Diseases, Internal Medicine, Oral Surgery, Orthopedics, Psychiatry, and Pulmonary;
  2) 95 Scovill St., Waterbury; Specialties: Internal Medicine and Pediatrics,
  3) FMG Behavioral Healthcare Outpatient Services; 100 Jefferson Square, Waterbury; Specialty: Outpatient Behavioral Health Services;
  4) 1981 East Main St., Waterbury; Specialty: Internal Medicine;
  5) 202 Water St., Naugatuck; Specialty: Internal Medicine;

6) FMG Primary Care Partners, 166 Waterbury Rd., Prospect; Specialties: Primary Care (Internal Medicine, OB/GYN, and Pediatrics), General Surgery and Breast Surgery;
7) FMG Wolcott Internal Medicine, 503 Wolcott Rd., First Floor, Wolcott; Specialty: Internal Medicine;
8) FMG Breast and Oncology Center, 33 Bullet Hill Rd., Suite 214, Southbury; Specialties: General Surgery and Breast Surgery;
9) 1320 West Main St., Waterbury; Specialties: Cardiology, Pulmonary (Sleep Medicine);
10) 140 Grandview Ave., Suite 4, Waterbury; Specialty: Gastroenterology;
11) 590 Middlebury Rd., Suite A, Middlebury; Specialty: General Surgery;
12) 1389 West Main St., Waterbury; Specialty: General Surgery;
13) 70 Heminway Park Rd., Watertown; Specialty: Internal Medicine; and
14) 56 Franklin St., 2nd Floor, Waterbury; Specialty: Cardiology.

- A 60% ownership interest in Diagnostic Imaging of Southbury, LLC, 385 Main St., Southbury;
- Saint Mary's Hospital Foundation, Inc., 56 Franklin St., Waterbury;
- Saint Mary's Indemnity Company, LLC;
- Saint Mary's Physician Partners, LLC (Accountable Care Organization);
- A 50% membership interest in the Harold Leever Regional Cancer Center, 1075 Chase Pkwy., Waterbury;
- A 50% membership interest in the Heart Center of Greater Waterbury, Inc., 1075 Chase Pkwy., Waterbury; and
- A 48% ownership interest in Naugatuck Valley MRI Limited Partnership, 4 locations.

In addition to the above entities, the Hospital offers health care services under its license at the following locations:

- Naugatuck Valley Surgical Center, 160 Robbins St., Waterbury;
- Naugatuck Urgent Care Center, 799 New Haven Rd., Naugatuck;
- Wolcott Urgent Care Center, 503 Wolcott Rd., Wolcott;
- West Main Health & Wellness Center, 1312 West Main St., Waterbury;
- Cardiovascular Diagnostic Center, 1320 West Main St., Waterbury;
- Occupational Health & Diagnostic Center, 146 Highland Ave., Waterbury;
- Saint Mary's Outpatient Center, 1981 East Main St., Waterbury;
- Saint Mary's Outpatient Behavioral Health Services, 100 Jefferson Sq., Waterbury;
- Saint Mary's Blood Draws:
  1) 133 Scovill St., Waterbury;
  2) 1981 East Main St., Waterbury;
  3) Union Square, Southbury; and
  4) 70 Hemingway Park Rd., Waterbury.

Figure 3 later in the Application depicts the organization of Saint Mary's and its affiliates.

Tenet Healthcare Corporation

Tenet Healthcare Corporation (previously defined as "Tenet") is a for-profit, investor-owned health care services company that was founded in 1967. Tenet has been headquartered in Dallas, Texas, since 2004. Tenet owns and operates 80 acute–care hospitals in 14 states and 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") which created the third largest investor-owned hospital company in the United States in terms of revenue and the third largest in number of hospitals owned. Tenet has expertise and experience in new care delivery models both in hospitals and in outpatient settings. It is committed to attracting the best talent in health care, which leads to better performance in terms of clinical quality and safety. The goal is to offer superior quality and patient services to meet community needs. Tenet has a significant amount of capital to invest in improving the quality of health care delivered at the Hospital and its affiliates, which, in turn, will positively impact the financial strength of the health care system in the state.

Tenet does not provide direct patient health care services. It enables existing health care providers to do more for their patients by investing time, talent and capital in local health care networks which continue to care for the patients in their service areas. Tenet will assist with investments in facilities and technology to remain competitive, to negotiate competitive contracts with managed care and other private payers, and to provide operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. Tenet's management services now support value-based performance through clinical integration, financial risk management and population health management. By owning both facilities in Waterbury, Tenet expects to realize significant benefits from Accountable Care Organizations ("ACOs") and bundled payment initiatives, and other value-based contracting arrangements.

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 redirect healthcare to a new model which focuses on value rather than volume.

In its first trial, Baptist Health System ("Baptist") (a Tenet health system), in San Antonio, Texas, participated in a CMS Acute Care Episode ("ACE") demonstration project for nine orthopedic diagnosis-related groups ("DRGs") and 28 cardiac DRGs which focused on whether improvements in quality could result when physicians and hospitals worked together under a new system of financial incentives. Baptist was one of only five systems nationally selected to participate in this innovative 3-year project. Central to this demonstration project was the determination of whether improvements in quality of care can result from the alignment of financial incentives between hospitals and physicians in such a way that they must coordinate care on a case-by-case basis. The results were positive. Physicians were able to coordinate care on a case-by-case basis, which improved quality and also led to cost

savings. For example, in orthopedics, Baptist achieved compliance in all five quality metrics, most significantly achieving 99% compliance in Surgical Care Improvement Project Core Measure Set 3. As this project moved forward, additional savings targets were set and higher quality goals implemented. The project has generated $10.1 million in savings in surgical implants and $1.2 million in gain share payments to participating physicians. The project has also saved the Medicare program over $3.9 million, of which $1.4 million was shared with patients. Baptist has taken many of the lessons learned from this program, including transparency and full collaboration, and has applied them to other service lines via management agreements or increased effectiveness of existing medical directorships. Baptist has been sharing its experiences and knowledge with the other Tenet markets, thus positioning these markets to participate in the next phase of bundled payments.

In the second trial, the Detroit Medical Center ("DMC") (a Tenet/Vanguard hospital) was one of only 32 health systems selected to participate in a CMS Pioneer Accountable Care Organization ("ACO"). DMC is the only Pioneer ACO consisting entirely of private physicians. For 2012, the ACO generated savings of $8 million. While 2013 results have not been announced, it is anticipated that 2013 savings will exceed those of 2012.

3. **Describe the terms of the proposed asset purchase between Tenet and SMHS (the "Asset Purchase"). This section should include, but is not limited to, a financial analysis of the transaction and descriptions of Tenet, SMHS, the new entity that is to be formed by Tenet to effect the acquisition and ownership of SMHS's assets (the "New SM Hospital"), 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, Tenet's commitment to spend $85 million dollars on capital expenditures and services improvements, and how Tenet intends to employ SMHS's physicians on staff. Provide copies of all contracts, agreements, and memoranda of understanding, schedules, and pro forma financial statements relating to the proposed Asset Purchase.**

TERMS OF TRANSACTION

Purchase Price

Pursuant to the proposed Asset Purchase Agreement, Tenet will pay $150 million for Saint Mary's assets relating to the Hospital and its related health care facilities, subject to certain adjustments, including a Net Working Capital Adjustment and reductions for liabilities relating to pension, retiree health, capital leases and any equity interests that do not transfer. (*See* Exhibit A, p. 11, Sec. 1.59).

Saint Mary's assets and liabilities, those included and excluded as part of the proposed transaction, are described below. All capitalized terms are defined in the Asset Purchase Agreement.

Assets Included in the Transaction

The assets to be purchased by Tenet include:

- the Owned Real property;
- the Personal Property;
- the Assumed Permits;
- the Saint Mary's Equity Interests;
- the Assumed Personal Property Leases;
- the Assumed Real Property Leases;
- the Assumed Contracts;
- the Advances;
- the Records;
- the Accounts Receivable;
- the Electronic Funds Transfer ("EFT") Account (other than cash in such EFT Account at the closing, which shall be an Excluded Asset);
- all usable inventories of supplies, drugs, food, janitorial and office supplies, and other disposable and consumables located at the Facilities, or used with respect to the operation of the Facilities (the term "usable" in this clause meaning non-obsolete and consumable within the ordinary course of business of the Facilities, consistent with past practices);
- the Facilities' website(s), together with the content therein (to the extent transferable), Intellectual Property (including the name "Saint Mary's Hospital" and all other Intellectual Property and telephone numbers used with respect to the operation of the Hospital), all goodwill associated therewith, and all applications and registrations associated therewith;
- to the extent assignable, all warranties (express or implied) and rights and claims assertable by (but not against) Saint Mary's related to the Purchased Assets;
- all good will associated with the Facilities and the Purchased Assets;
- any current assets with respect to the operation of the Facilities that are not otherwise specifically described in the Asset Purchase Agreement and that are included in the Final Net Working Capital Amount;
- subject to provisions of the Asset Purchase Agreement, all insurance proceeds with respect to the Purchased Assets or the Assumed Liabilities (including insurance proceeds received by Saint Mary's or payable to Saint Mary's and all deductibles, copayments, and self-insurance requirements payable by Saint Mary's) arising in connection with damage to the Purchased Assets occurring on or prior to the Closing to the extent not expended by Saint Mary's for the repair or restoration of the Purchased Assets;
- claims of Saint Mary's against third parties relating to the Purchased Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, other than those listed in the Asset Purchase Agreement and other claims relating to the Excluded Assets or Excluded Liabilities;
- Saint Mary's provider agreements with Government Payment Programs;

- all other property, other than the Excluded Assets, of every kind, character, or description owned by Saint Mary's and used or held for use in the Facilities, whether or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by Saint Mary's in connection with the operations of the facilities or the Purchased Assets; and
- the interest of Saint Mary's in all property of the foregoing types, arising or acquired in the ordinary course of the business of Saint Mary's with respect to the Facilities prior to the Closing.

(*See* Exhibit A, pp. 10-11, Sec.1.58)

Assets Excluded from the Transaction

The assets to be excluded from the transaction and retained by Saint Mary's include:

- all interests in, and assets related to the following entities, including the names thereof:
  - Saint Mary's Hospital Foundation, Inc.
  - Saint Mary's Indemnity Company, LLC
- cash, cash equivalents marketable securities and short-term investments, including, without limitation, cash in the EFT Account immediately prior to the Effective Time;
- 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), trusts related to employee benefits, trusts related to self-insurance, donor-restricted assets, beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;
- all intercompany receivables of Saint Mary's with any of its Affiliates;
- any current assets of Saint Mary's that are not included in the Final Net Working Capital Amount;
- all rights to refunds, credits, deposits, prepayments, or the equivalent owing to Saint Mary's from any taxing authority resulting from periods prior to the Effective Time, and the right to pursue appeals of same;
- all claims, rights, interests, and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid with respect to the Facilities to any third party with respect to periods prior to the Closing;
- all bank accounts relating to the Facilities, other than the EFT Account;
- all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine, or any other cognizable privilege or protection of Saint Mary's that are not related to any legal matter or Proceeding or potential Proceeding which is an Assumed Liability;
- any Cost Report settlements with respect to Cost Report periods ended on or prior to the Closing;

- any assets owned and provided by vendors of goods or services to the Facilities;
- unclaimed property of any third party with respect to the operation of the Facilities, including, without limitation, property that is subject to applicable escheat Laws;
- all rights, claims, and choses in action of Saint Mary's with respect to the operation of the Facilities, with respect to periods prior to the Closing, and any payments, awards, or other proceeds resulting therefrom;
- the Excluded Contracts;
- the portions of inventory, prepaid expenses and the like, and other Purchased Assets disposed of, expended, or canceled, as the case may be, by the Facilities prior to the Closing in the ordinary course of business;
- all organizational documents of Saint Mary's and its Affiliates, unless the equity interest of such Affiliate is being transferred to Tenet at the Closing;
- all Permits and Records not legally transferable or assignable to Tenet or not relating to the ownership of the Purchased Assets or the operation of the Facilities;
- all equity interests in SMH, Inc.;
- all assets of the Partial Subsidiarics, including without limitation, all assets of Diagnostic Imaging of Southbury, LLC; and
- any other assets specifically identified in Schedule 1.26(t) of the Asset Purchase Agreement.

(*See* Exhibit A, pp. 4-5, Sec. 1.26)

Assumed Liabilities

The liabilities to be assumed by Tenet after the Closing include:

- those liabilities and obligations arising after the Effective Time pursuant to the Assumed Contracts, Assumed Real Property Leases and Assumed Personal Property Leases;
- Saint Mary's obligations arising after the Closing, with respect to any Assumed Permits, but excluding any liabilities or obligations under such Assumed Permits for acts or omissions occurring or conditions existing prior to the Effective Time;
- the trade accounts payable and current liabilities of the Facilities as of the Effective Time, but only to the extent such accounts payable and current liabilities are included in the calculation of the Final Net Working Capital Amount;
- obligations and liabilities as of the Effective Time with respect to (i) vacation time, (ii) sick time, (iii) any other paid time off, and (iv) unused health reimbursement account balances of Saint Mary's employees who accept employment with Tenet as of the Effective Time, and related taxes, but only to the extent obligations and liabilities for vacation time, sick time and any other paid time off are included in the calculation of the Final Net Working Capital Amount and only to the extent that such reimbursement account balances are actually transferred to Tenet's applicable benefit plan from Saint Mary's applicable benefit plan;

- liabilities or obligations with respect to Taxes relating to the Facilities and the Purchased Assets with respect to periods commencing on or after the Effective Time;
- all Taxes allocable to Tenet pursuant to Section 2.5, Section 11.7 and Section 13.10 of Exhibit A;
- all outstanding liabilities under the Pension Plan for Employees of Saint Mary's Hospital Corporation and Saint Mary's retiree medical plan (the "Retiree Medical Plan"); and
- any other liabilities specifically identified in Schedule 1.9.

(*See* Exhibit A, pp. 2-3, Sec. 1.9)

Liabilities Retained by Saint Mary's

The liabilities to be retained by Saint Mary's after the Closing include:

- those claims and obligations (if any) specified in Schedule 1.28(a) of the Asset Purchase Agreement;
- any liabilities or obligations associated with or arising out of any of the Excluded Assets, including, without limitation, the Excluded Contracts;
- Taxes incurred by Saint Mary's, the Facilities or in connection with the operation of the Facilities, with respect to periods prior to the Effective Time (provided, however, that this provision shall not apply to any and all Taxes payable with respect to any employee benefits constituting Assumed Liabilities and any Taxes allocable to Tenet;
- liabilities or obligations arising out of or in connection with certain Proceedings described in the Asset Purchase Agreement and claims or potential claims for medical malpractice or general liability relating to events that occurred or that allegedly occurred prior to the Effective Time;
- liabilities arising from any violation of Law by Saint Mary's or their directors, officers, employees, representatives, and agents;
- liabilities and obligations arising out of transactions, commitments, infringements, acts or omissions (including the breach by Saint Mary's of any Contract) by or on behalf of Saint Mary's or its employees, agents or independent contractors occurring prior to, on or after the Closing Date;
- any obligation or liability asserted under the federal Hill-Burton program or other restricted grant and loan programs with respect to the ownership or operation of the Facilities or the Purchased Assets prior to the Effective Time;
- all liabilities and obligations relating to any oral agreements, oral contracts, or oral understandings with any referral sources including, but not limited to, physicians, made prior to the Effective Time unless reduced to writing and expressly assumed as part of the Assumed Contracts;
- any long-term debt obligations of Saint Mary's;

- liabilities or obligations with respect to periods prior to the Effective Time arising under the terms of Government Payment Programs or commercial third party programs, including, without limitation, any retroactive denial of claims and civil monetary penalties;
- Cost Report settlement payables relating to all Cost Report periods prior to the Effective Time; and
- any liabilities or obligations with respect to any employees of Saint Mary's, including liabilities under any employee health and welfare benefit plans, unemployment compensation claims, workers' compensation claims and liabilities for employee wages and benefits, except to the extent reflected in the Final Net Working Capital Amount.

(*See* Exhibit A, pp. 5-6, Sec. 1.28)

Capital Commitment

After the closing, Tenet agrees to spend not less than $85 million over the subsequent 7 year period on capital expenditures (including routine and non-routine capital expenditures and ongoing/deferred maintenance), including expansion or development of healthcare services, development of a comprehensive ambulatory network, creation of a physician platform, expansion and integration of clinical and information technology, quality improvement programs, expenditures for new capital or equipment replacement, and the acquisition, development and improvement of hospital, ambulatory, medical office space, or other healthcare services in the greater Waterbury community. Tenet shall be relieved of this obligation in the event that any legal requirement is enacted or imposed after the closing that (i) discriminates against, or adversely affects a disproportionate number of for-profit hospitals or other for-profit healthcare entities, or (ii) causes Tenet to suffer a material decline in earnings.

Local Health System Board

A local health system board (the "Advisory Board") will be established. The initial members of the Advisory Board will include the Archbishop of Hartford (the "Archbishop") (or his designee), two representatives of the Archbishop, the Hospital CEO, local community leaders from the Hospital's Board of Directors immediately prior to the Closing, and members of the Hospital's medical leadership. The Advisory Board shall be responsible for, among other things:

(1) developing and providing recommendations concerning the Facilities' vision, mission and values statements; the Facilities' strategic plan; and operating and capital budgets for the Facilities;

(2) providing recommendations concerning the selection of, and providing periodic evaluations of, the Hospital's chief executive officer;

(3) monitoring operating performance of the Facilities;

(4) monitoring performance improvement initiatives at the Facilities;

(5) granting medical staff privileges and taking disciplinary action consistent with the medical staff bylaws;

(6) assuring the quality of medical care and medical staff compliance with applicable accreditation requirements;

(7) supporting physician recruitment efforts; and

(8) fostering community relationships and identifying service and education opportunities.

The Advisory Board will have a standing committee known as the "Mission Integration Committee" which will be responsible for oversight of the integration of mission and core values into the New SM Hospital's activities, including the New SM Hospital's services and benefits to the community in conformance with the Directives.

During the 5-year period following the Effective Time of the transaction, the following actions, subject to certain limited exceptions, shall require approval, by majority vote, of the Advisory Board: (i) the merger, dissolution, consolidation, sale or other disposition of the New SM Hospital or all or substantially all of Tenet's assets in Waterbury, Connecticut; and (ii) Tenet ceasing operation of the New SM Hospital as an acute care hospital with an emergency department. Thereafter, Tenet shall not take any of the actions described above without first consulting with the Advisory Board. Furthermore, Tenet shall at all times consult with the Advisory Board regarding: (i) the development of, and changes to, the Hospital's strategic plan; (ii) the Hospital's operating and capital budgets; and (iii) the appointment and removal of the Hospital's CEO.

Saint Mary's Foundation

The Saint Mary's Foundation, which is further discussed in responses to Questions 9 and 10, will not be included in the assets to be purchased by Tenet. At the Closing, and after proceeds from the sale are distributed, it is estimated that the Foundation will have a net worth of approximately $135,983,000. Certain of the funds in the Foundation are restricted and the remainder of the funds will be used for local health care needs.

The Foundation shall also have a "right of first opportunity" upon a sale of the New SM Hospital, which means that it shall have the right to acquire the New SM Hospital any time during the 5 year period following the Closing if Tenet proposes to sell its membership interest in the acquiring entity, or all or substantially all of the assets of the New SM Hospital.

Other Key Terms

- ***Catholic Heritage and Identity***

  Following the proposed transaction, the New SM Hospital will retain its name, its Catholic identity and continue to honor its Catholic heritage and operate in accordance the Ethical and Religious Directives for Catholic Health Care Services (previously defined as the "Directives"). There will be an Ethics Committee which will be responsible for the day-to-day monitoring of compliance with the Directives and other ethics-related matters, whose Chairman will be appointed, and members approved by, the Archbishop. All current Catholic names of existing buildings as well as symbols, the chapel, and the cross on the building will be maintained. The New SM Hospital will continue to have a Pastoral Care Department, whose Director will be appointed by the Archbishop and will serve on the Senior Management Team of the New SM Hospital. The Archbishop also has the ability at any time in his sole discretion to withdraw recognition of the New SM Hospital as a Catholic identity, if he chooses, and to require that the right to the name, the religious artifacts and others symbols of Catholic identity be withdrawn.

- ***Community Benefit Standards***

  Following the proposed transaction, the New SM Hospital will continue to operate in accordance with the "community benefit standards" required of tax-exempt hospitals (as set forth in Internal Revenue Service Ruling 69-545), including without limitation, agreeing to (i) accept all patients enrolled in Government Payment Programs, (ii) accept all emergency patients without regard to age, race or ability to pay, (iii) maintain an open medical staff, and (iv) promote public health, wellness and welfare in the community through the provision of health care at a reasonable cost. The New SM Hospital will also retain and continue to follow its current charity care and uncompensated care policies and remain involved in its community benefit activities.

- ***Employees and Medical Staff***

  Tenet 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 Saint Mary's 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 Hospital who are in good standing as of the closing shall maintain medical staff privileges following the Closing.

- ***Conditions Precedent to Closing***

  Thc conditions precedent to Closing include, but are not limited to (unless waived), the following: all representations and warranties of the parties are true, the parties have obtained satisfactory evidence of governmental approvals, consents to

assignments of contracts and leases have been received by Tenet, Transaction Documents have been received by the parties, there are no Material Adverse Effects, all canonical approvals have been received, and Tenet shall have assumed the Amended and Restated Employment Agreement between the Hospital and Chad Wable, dated December 31, 2010.

- ***Covenant Not to Compete***

  Saint Mary's covenants that from the Closing Date until the fifth anniversary of the Closing Date, that it will not, directly or indirectly, except as a consultant or contractor to or of Tenet, own, lease, manage, operate, control, be employed by, maintain or continue any interest or participate in any manner with the ownership, leasing, management, operation or control of any business that offers services in competition with the Facilities within a thirty mile radius of the New SM Hospital without Tenet's prior written consent. Saint Mary's will not be precluded from participating in activities that promote health care services for residents of the communities historically served by Saint Mary's through the Hospital.

- ***Sale of Hospital in Excess of Purchase Price***

  In the event of a sale of the New SM Hospital, whether by merger, sale or other transaction, at any time prior to the third anniversary of the Closing, for a purchase price in excess of the amount paid by Tenet in this transaction, 20% of such excess shall be transferred to Saint Mary's or its designee.

- ***Termination Prior to Closing***

  The Asset Purchase Agreement may be terminated at any time: (i) on or prior to the Closing Date by mutual consent of the parties; (ii) by Tenet if any event occurs or condition exists which causes Saint Mary's to be unable to satisfy one or more conditions to the obligations of Tenet to consummate the transaction; (iii) by Saint Mary's if any event occurs or condition exists which causes Tenet to be unable to satisfy one or more conditions to the obligation of Saint Mary's to consummate the transaction; and (iv) by either party if the Closing Date shall not have taken place on or before May 1, 2015.

- ***Termination Fee***

  In the event either party (Saint Mary's or Tenet) refuses to close the transactions contemplated by the Asset Purchase Agreement when all conditions are met, then such "breaching" party shall pay to the other party a termination fee equal to $4.5 million.

- ***Indemnification***

  Subject to certain limitations set forth in the Asset Purchase Agreement, Saint Mary's shall indemnify Tenet against (i) any inaccuracy, misrepresentation or breach of warranty under the Asset Purchase Agreement or any Transaction Document to which Saint Mary's is a party; (ii) any breach by Saint Mary's of, or any failure by Saint Mary's to perform, any covenant or agreement required to be performed by Saint Mary's under the Asset Purchase Agreement or any Transaction Document; (iii) any of the Excluded Liabilities; (iv) any claim made by a third party with respect to the ownership of the Purchased Assets or the operation of the Facilities prior to the Effective Time; (v) any liabilities, costs or expenses incurred by Tenet or its Affiliates in connection with the Transfer Act Activities; or (vi) any liabilities, costs or expenses incurred by Tenet or its Affiliates for asbestos abatement at any of the Facilities.

  Subject to certain limitations set forth in the Asset Purchase Agreement, Tenet shall indemnify Saint Mary's against (i) any inaccuracy, misrepresentation or breach of warranty by Tenet under the Asset Purchase Agreement or in any Transaction Document to which Tenet is a party; (ii) any breach by Tenet of, or any failure by Tenet to perform, any covenant or agreement required to be performed by Tenet under the Asset Purchase Agreement or any Transaction Document; (iii) from and after the Effective Date, any Assumed Liabilities; or (iv) any claim made by a third party with respect to the ownership of the Purchased Assets or the operation of the Facilities following the Effective Time.

- ***Indemnity Reserve***

  Saint Mary's agrees to maintain an indemnity reserve in the amount of $15 million for a period of 18 months after the Closing, subject to certain adjustments, so that Tenet will have meaningful financial recourse against Saint Mary's for any potential indemnification claims.

FINANCIAL ANALYSIS

Flow of Funds

Tenet offered Saint Mary's a purchase price of $150 million, which is inclusive of $6.3 million of normalized net working capital. Net working capital is defined as non-cash current assets less non-debt current liabilities. The $6.3 million of normalized net working capital was determined by taking an average of the net working capital amounts at the end of the month over the last twelve months. At the time of the Closing, any net working capital amount above $6.3 million would be a positive purchase price adjustment for Saint Mary's and any net working capital amount below $6.3 million would be a negative purchase price adjustment for Saint Mary's. As of the May 31, 2014, balance sheet, the net working capital amount was $10.9 million so, there is a potential

positive purchase price adjustment of $4.6 million for Saint Mary's if net working capital remains the same as of the Effective Time.

Tenet's offer states that it is willing to assume the Saint Mary's pension liability, but that the value of the pension liability would reduce the purchase price. As of the May 31, 2014, balance sheet, the pension liability was $52.5 million, so the purchase price would be reduced by that amount. The pension liability is subject to change based on a valuation done as of the Effective Time.

As part of the transaction, Saint Mary's will be retaining all cash, cash equivalents, marketable securities and short-term investments.

In addition, as part of the transaction, Saint Mary's will retain those liabilities enumerated above (*see* Table 3 below).

As noted above, Saint Mary's agrees to maintain an indemnity reserve in the amount of $15 million for a period of eighteen months after the Closing, subject to certain adjustments. Funds no longer subject to the indemnity reserve will be released and become available as unrestricted cash.

The closing costs for the transaction include both the cost of tail insurance and the investment banking fees paid to Hammond Hanlon Camp, LLC. The total estimated closing costs are $5.0 million.

After taking into account all the positive and negative adjustments to the purchase price, as well as assets and liabilities retained by the Foundation, at the time of the Closing, the Foundation will retain approximately $106.7 million in cash (*see* Table 3 below). In addition, Tenet agreed to spend not less than $85 million in the next seven years following the Closing for healthcare services, capital expenditures, routine and non-routine capital expenditures and ongoing/deferred maintenance to health services in the greater Waterbury community. (Exhibit A, p. 60, Sec. 11.16)

Saint Mary's Foundation, Inc.

Table 1 below demonstrates the estimated net proceeds of funds distribution.

Table 1: Net Proceeds to the Foundation

Net Proceeds Analysis *($000's)*			
Initial Consideration	**$**	**150,000**	*
Assumed Liabilities			
Pension Liability		52,437	
Capital Leases		1,130	
Total Assumed Liabilities		53,567	
Purchase Price	**$**	**96,433**	**
Net Debt to be Satisified at Closing			
Current Portion of Long Term Debt		2,458	
Long Term Obligations		19,501	
Less:			
Existing Cash		29,088	
Assets held under bond indenture		3,176	
Net Debt / (Net Cash)		(10,305)	
Cash Balance after Debt Satisfaction	**$**	**106,738**	

* Includes net working capital of $6.3 million. Subject to adjustment based upon actual net working capital at the Effective Time

** $15 million of the Cash Purchase Price is restricted as an indemnity reserve per the Asset Purchase Agreement and will held outside the Foundation

Note: The pension liability is subject to change based on a valuation done as of the Effective Time.

The Foundation is further discussed in responses to Questions 9 and 10.

Use of Proceeds – Saint Mary's

Tables 2 and 3 below provide further detail as to how Saint Mary's will use the proceeds of the transaction.

Table 2: Saint Mary's Consolidated Balance Sheet Allocation

Balance Sheet Allocation
($000's)

Reference		*A*	*B*	*C*	*D*	*E=A+B+C+D*	*F=A-E*
			Excluded Entities				
	2013 Audit	**Actual May 2014**	**Legacy Saint Mary's Hospital Foundation**	**Saint Mary's Indemnity Company, LLC**	**Eliminations**	**Total Excluded Entities**	**Base Balance Sheet**
ASSETS							
Cash	$ 29,939	$ 27,527	$ 1,031	$ -	$ -	1,031	$ 26,496
Short term Investments	29	22	-	-	-	-	22
Current portion of assets whose use is limited	8,039	9,483	-	6,891	-	6,891	2,592
Accounts Receivable	30,768	31,096	27	1,768	(1,768)	27	31,069
Other Current Assets	4,834	8,149	2	5,981	(5,138)	845	7,304
Total Current Assets	73,609	76,277	1,060	14,640	(6,906)	8,794	67,483
Marketable Securities	22,365	24,600	4,149	-	-	4,149	20,451
Assets Whose Use is Limited							
By Donor and Held in Trust	15,258	15,881	-	-	-	-	15,881
For Estimated Self Insurance Liability	31,394	34,481	-	34,481	-	34,481	-
By Bond Indenture	4,324	5,768	-	-	-	-	5,768
Other	6	6	-	-	-	-	6
(less) current portion	(8,039)	(9,483)		(6,891)	-	(6,891)	(2,592)
Total Assets Whose Use is Limited	42,943	46,653	-	27,590	-	27,590	19,063
Property, Plant, and Equipment	64,952	63,340	5	-	-	5	63,335
Investment in Joint Ventures	10,697	9,871	-	-	-	-	9,871
Deferred Financing Costs	128	111	-	-	-	-	111
Other Noncurrent Assets	241	241	-	-	-	-	241
Total Other Assets	11,066	10,223	-	-	-	-	10,223
Total Assets	$ 214,935	$ 221,093	$ 5,214	$ 42,230	$ (6,906)	$ 40,538	$ 180,555
LIABILITIES AND NET ASSETS							
Current Portion of Long Term Debt	$ 2,490	$ 2,452	-	-	-	-	$ 2,452
Accounts Payable	20,985	14,672	20	-	-	20	14,652
Accrued Payroll Expenses	4,734	4,499	-	-	-	-	4,499
Due to Third Parties	6,035	5,030	-	-	-	-	5,030
Accrued Other Expenses	16,486	16,485	30	9,154	(1,768)	7,416	9,069
Total Current Liabilities	50,730	43,138	50	9,154	(1,768)	7,436	35,702
Long Term Obligations	20,374	20,029	-	-	-	-	20,029
Estimated Self Insurance Liability	21,908	24,630	-	21,221	-	21,221	3,409
Unfunded Pension Liability	58,823	52,437	-	-	-	-	52,437
Other Long Term Liabilities	10,172	11,735	-	-	-	-	11,735
Total Long Term Liabilities	111,277	108,831	-	21,221	-	21,221	87,610
Unrestricted	34,404	49,982	2,009	11,855	(5,138)	8,726	41,256
Temporarily Restricted	2,269	2,269	2,187	-	-	2,187	82
Permanently Restricted	16,255	16,873	968	-	-	968	15,905
Total Net Assets	52,928	69,124	5,164	11,855	(5,138)	11,881	57,243
Total Liabilities and Fund Balance	$ 214,935	$ 221,093	$ 5,214	$ 42,230	$ (6,906)	$ 40,538	$ 180,555

Table 2: Saint Mary's Consolidated Balance Sheet Allocation (continued)

Balance Sheet Allocation
($000's)

Reference	*G*	*H*	*G+H=F*	*H*	*I*	*J=H-I*	*E*	*K=J+E*
	Base Balance Sheet Allocation			**Total Retained by Seller**				
	Included in Transaction	**Retained by Seller**	**Base Balance Sheet**	**Retained by Seller**	**Net Debt**	**Retained by Seller after Net Debt**	**Total Excluded Entities**	**Total Retained by Seller**
ASSETS								
Cash	$ -	$ 26,496	$ 26,496	$ 26,496	$ 26,496	$ -	$ 1,031	$ 1,031
Short term Investments	-	22	22	22		22	-	22
Current portion of assets whose use is limited	-	2,592	2,592	2,592	$ 2,592	-	-	-
Accounts Receivable	31,069	-	31,069	-	-	-	27	27
Other Current Assets	6,863	441	7,304	441	-	441	845	1,286
Total Current Assets	37,932	29,551	67,483	29,551	29,088	463	1,903	2,366
Marketable Securities	-	20,451	20,451	20,451	-	20,451	4,149	24,600
Assets Whose Use is Limited								
By Donor and Held in Trust	-	15,881	15,881	15,881	-	15,881	-	15,881
For Estimated Self Insurance Liability	-	-	-	-	-	-	34,481	34,481
By Bond Indenture	-	5,768	5,768	5,768	5,768	-	-	-
Other	-	6	6	6	-	6	-	6
(less) current portion		(2,592)	(2,592)	(2,592)	(2,592)			
Total Assets Whose Use is Limited	-	19,063	19,063	19,063	3,176	15,887	34,481	50,368
Property, Plant, and Equipment	63,335	-	63,335	-	-	-	5	5
Investment in Joint Ventures	9,871	-	9,871	-	-	-	-	-
Deferred Financing Costs	-	111	111	111	-	111	-	111
Other Noncurrent Assets	241	-	241	-	-	-	-	-
Total Other Assets	10,112	111	10,223	111	-	111	-	111
Total Assets	$ 111,379	$ 69,176	$ 180,555	$ 69,176	$ 32,264	$ 36,912	$ 40,538	$ 77,450
LIABILITIES AND NET ASSETS								
Current Portion of Long Term Debt	$ 602	$ 1,850	$ 2,452	$ 1,850	$ 1,850	$ -	$ -	$ -
Accounts Payable	14,399	253	14,652	253	-	253	20	273
Accrued Payroll Expenses	4,499	-	4,499	-	-	-	-	-
Due to Third Parties	291	4,739	5,030	4,739	-	4,739	-	4,739
Accrued Other Expenses	8,254	815	9,069	815	608	207	7,416	7,623
Total Current Liabilities	28,045	7,657	35,702	7,657	2,458	5,199	7,436	12,635
Long Term Obligations	528	19,501	20,029	19,501	19,501	-	-	-
Estimated Self Insurance Liability	-	3,409	3,409	3,409	-	3,409	21,221	24,630
Unfunded Pension Liability	52,437	-	52,437	-	-	-	-	-
Other Long Term Liabilities	795	10,940	11,735	10,940	-	10,940	-	10,940
Total Long Term Liabilities	53,760	33,850	87,610	33,850	19,501	14,349	21,221	35,570
Unrestricted	29,574	11,788	41,256	11,788	10,305	1,483	8,726	10,209
Temporarily Restricted	-	-	82	-	-	-	2,187	2,187
Permanently Restricted	-	15,881	15,905	15,881	-	15,881	968	16,849
Total Net Assets	29,574	27,669	57,243	27,669	10,305	17,364	11,881	29,245
Total Liabilities and Fund Balance	$ 111,379	$ 69,176	$ 180,555	$ 69,176	$ 32,264	$ 36,912	$ 40,538	$ 77,450

Table 3: Saint Mary's Proforma Balance Sheet – Foundation

Foundation Proforma Balance Sheet	
($000's)	
Assets Retained by Foundation	
Cash Balance after Debt Satisfaction	$ 106,738 *
Cash from Exlcuded Entities	1,031
Short term Investments	22
Accounts Receivable	27
Other Current Assets	1,286
Marketable Securities	24,600
By Donor and Held in Trust	15,881
For Estimated Self Insurance Liability	34,481
Other	6
Property, Plant, and Equipment	5
Deferred Financing Costs	111
Total Assets Retained by Foundation	$ 184,188
Liabilites Retained by Foundation	
Accounts Payable	$ 273
Due to Third Parties	4,739
Accrued Other Expenses	7,623
Estimated Self Insurance Liability	24,630
Other Long Term Liabilities	10,940
Total Liabilities Retained by Foundation	$ 48,205
Net Assets Retained by Foundation	$ 135,983
Total Liabilities and Net Assets	$ 184,188

* $15 million of the Cash Purchase Price is restricted as an indemnity reserve per the Asset Purchase Agreement and will held outside the Foundation

4. **Describe the due diligence undertaken by SMHS in deciding to enter into the Asset Purchase agreement. This section should include, but is not limited to, considerations regarding the current financial condition of SMHS and any projected financial condition of SMHS, any professional assessments of or reports regarding SMHS or Tenet, any and all alternatives explored by SMHS or other offers received by SMHS, the reasons for rejecting such alternatives and offers, SMHS's selection of Tenet, 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.**

Saint Mary's arrived at the decision to enter into the Asset Purchase Agreement with Tenet after a lengthy and thorough process.

In 2002, Saint Mary's had multiple years of operating losses that missed budgeted levels for performance. Saint Mary's poor operating performance weakened debt and liquidity ratio measures, and Saint Mary's was nearing technical default on its bonds. In addition, the lack of any positive cash flow prevented Saint Mary's from investing in its aging plant. Saint Mary's installed a new management team, began a Revised Renovation Program, and the organization began to plan for the future of Saint Mary's as a stand-alone entity.

In December 2003, after evaluating Saint Mary's viability as a stand-alone organization, the Saint Mary's Board adopted an Affiliation Strategy as part of its Strategic Plan. In May 2004, the Saint Mary's Board appointed its first Affiliation Task Force, which developed a White Paper on the Principles of Affiliation. By July 2004, the Task Force submitted its official recommendation to pursue an affiliation with Waterbury Hospital ("Waterbury"). In December 2004, an Affiliation Workgroup was formed to explore a possible affiliation between Saint Mary's and Waterbury. In 2005 and 2006, Saint Mary's was in default of its bond covenants.

In June 2006, a third-party consulting firm, retained by Saint Mary's, presented its findings on the potential synergies from which Saint Mary's and Waterbury would benefit in an affiliation. However, Waterbury was hesitant to pursue an affiliation primarily due to Saint Mary's significantly underfunded pension plan, which had a 48% funded pension ratio at the time. In the summer of 2006, Saint Mary's, along with Shattuck Hammond Partners serving as financial advisor, distributed a Confidential Information Memorandum ("CIM") to potential partners. In December 2006, Shattuck Hammond distributed the CIM to eight national and local healthcare systems and not-for-profit hospitals (six of the eight were Catholic healthcare systems). Saint Mary's received no viable proposals from the 2006 marketing process, again primarily due to the size of the unfunded pension liability, large debt balance, and the previous multiple years of operating issues.

In April 2007, the Affiliation Workgroup decided to again explore a potential affiliation between Saint Mary's and Waterbury. Saint Mary's and Waterbury made two presentations to Connecticut State officials summarizing the studies that supported a local consolidation of

the two hospitals. The Office of Health Care Access completed a dedicated study of the Waterbury area in response to both Saint Mary's and Waterbury being categorized as "financially distressed."

Saint Mary's and Waterbury shared the same vision to create financially sustainable, consolidated healthcare delivery systems that would improve access to quality healthcare in the Waterbury community. However, after several years, Saint Mary's and Waterbury were not able to come to acceptable terms to a merger agreement. Ultimately, merger discussions were terminated in 2008 due to lack of capital funding to support anticipated costs of the merger. Saint Mary's also found the arrangement to fund the pension plan in a potential Waterbury merger to be inadequate, as the funding was contingent on financial performance of the new hospital and not guaranteed.

In 2009, Saint Mary's initiated a new strategic planning process with its Board of Directors. Saint Mary's developed a consolidated five-year strategic capital plan and set operational and financial targets. Saint Mary's studied its ability to (1) remain a stand-alone entity while continuing to meet the healthcare needs of the community, (2) adequately fund its pension plan and service its debt, and (3) invest capital in its ongoing plant (collectively, the "Goals"). During this period, LHP Hospital Group, Inc. ("LHP") contacted Saint Mary's regarding a potential joint venture. Saint Mary's provided LHP with requested due diligence material and LHP submitted a preliminary offer to form a joint venture with Saint Mary's.

As a result of its strategic planning process, Saint Mary's decided that as an independent organization it would not be able to generate sufficient capital to meet its Goals. Recognizing the need for a capital partner, the Board appointed the Strategic Partner Task Force in July 2010 (the "Task Force"). The following individuals were invited to join the Task Force: Garrett Casey, Stephen R. Griffin, Esq., Robert Mazaika, Joseph A. Mengacci, Esq., James C. Smith, and Jerome Sugar, M.D.

The purpose of the Task Force was to: (1) confirm Saint Mary's objectives and principles for a partnership, (2) confirm Saint Mary's long-term strategic partnership strategy, (3) review all relevant strategic partners and partnership options, and (4) develop a recommendation for a strategic partner and partnership structure to the Board of Directors. The Board authorized the Task Force to pursue strategic affiliations. Morgan Keegan (acquirer of Shattuck Hammond) contacted 19 potential strategic parties, both not-for-profit and for-profit companies, of which 16 signed Confidentiality Agreements and received a CIM. Of the 16 parties, five interested parties submitted asset purchase or joint venture proposals. One additional party submitted a services agreement proposal with no numerical values proposed. The initial Indications of Interest from these six parties provided an Implied Enterprise Value range of $70.5 million to $190.4 million.

After receiving their initial Indications of Interest, Saint Mary's had management meetings with four of the six parties. One of the parties removed itself from the selection process prior to the management meetings. Since Saint Mary's was not contemplating entering into a services agreement relationship and was only pursing potential joint venture or sale options, it removed from the selection process the party offering only the services agreement

proposal. Following initial meetings, Saint Mary's and Morgan Keegan participated in site visits at locations for three of the parties. In October 2010, the four parties were asked to submit best and final offers. A new potential partner, along with its joint venture partner, also submitted an initial Indication of Interest at this time. The revised and final Indications of Interest provided an Implied Enterprise Value range of $104.1 million to $198.7 million.

On November 11, 2010, Saint Mary's entered into a Letter of Intent with one of the parties to form a joint venture. Saint Mary's terminated the Letter of Intent with that party on December 24, 2010, as both parties were unable to reach mutually acceptable terms on the transaction. Saint Mary's and Morgan Keegan then confirmed that LHP and one additional party still retained interest in forming a joint venture and held conference calls with them and received updated proposals from both parties. The Affiliation Task Force met on January 4, 2011, to review the proposals and select a preferred partner. In the final Indications of Interest, the proposal from the non-LHP party valued Saint Mary's with an Implied Enterprise Value lower than that in the LHP proposal.

The Task Force recommended entering into an 80%/20% joint venture with LHP and cited four key reasons: financial attractiveness of the offer; availability of capital, clinical and managerial resources at LHP; local control; and cultural fit between Saint Mary's and LHP. On January 13, 2011, Saint Mary's entered into a Letter of Intent with LHP. Saint Mary's and LHP performed extensive due diligence review of each other. Saint Mary's and LHP finalized the Definitive Agreement, pending governmental approval in March 2011. Saint Mary's and LHP worked on a Certificate of Need application for approval of a Joint Venture and submitted its filing on July 21, 2011.

In August 2011, Saint Mary's and LHP began discussions with Waterbury to potentially include them in the Joint Venture. After several discussions, Waterbury agreed to become part of a three-way Joint Venture. In August 2012, LHP terminated discussions with Saint Mary's regarding the Joint Venture with Saint Mary's and Waterbury.

In September 2012, Saint Mary's began discussions with a national, faith-based, not-for-profit in conjunction with its search for a capital partner. The aforementioned party submitted a Letter of Intent on October 29, 2012, for a cash purchase price ranging from $115.0 million to $135.0 million plus assumption of the pension liability. The party performed extensive due diligence on Saint Mary's and submitted several revisions to its Letter of Intent. On March 20, 2013, the party submitted the final revision to its Letter of Intent, which eliminated the cash purchase price and included the assumption of the pension liability. Ultimately, Saint Mary's and the party were unable to reach agreement on key terms.

During Spring 2013, Hammond Hanlon Camp LLC ("H2C") (a newly formed firm founded by the key individuals advising Saint Mary's from Morgan Keegan) and Saint Mary's commenced a new process and contacted six organizations that signed confidentiality agreements with Saint Mary's and were granted initial access to the data room. One of the parties terminated discussions with Saint Mary's due to their strategic focus on other markets outside of Waterbury. A second party ("Party 2") wanted to delay commencing discussions due to their focus on closing an unrelated affiliation. H2C sent transmittal letters to three

organizations. The additional two parties that H2C contacted did not express an interest in Saint Mary's.

In May 2013, the three parties who received transmittal letters all submitted non-binding Indications of Interest. One of the parties submitted a revised non-binding Indication of Interest. Another party submitted a bid that was well below the other two offers. Although Party 2 had not submitted a bid, it had a meeting with Saint Mary's to continue to express its interest. Additionally, Saint Mary's had a meeting with another potential partner, a not-for-profit Catholic hospital ("Party 3").

In June 2013, the two parties who submitted Indications of Interest with the highest offers, which included Vanguard, were invited to participate in Round 2 of the latest process. Both parties performed extensive due diligence on Saint Mary's, including week-long site visits. In August 2013, one of the parties withdrew interest in Saint Mary's due to its concerns regarding the healthcare landscape in Connecticut. On September 5, 2013, Vanguard submitted a revised non-binding Indication of Interest for Saint Mary's with a $150 million purchase price. On September 20, 2013, Vanguard met with the Task Force to discuss its latest offer and its process with Saint Mary's going forward.

Saint Mary's and Tenet (formerly Vanguard) continued negotiating the final terms of the asset purchase agreement. In early 2014, Party 2 and Saint Mary's reengaged in discussions. In April 2014, both Party 2 and Tenet had separate meetings with the Task Force to express their continued interest in Saint Mary's.

Saint Mary's and Party 2 continued negotiating the final terms of an affiliation agreement. Simultaneously, Saint Mary's and Tenet continued negotiating the final terms of the Asset Purchase Agreement. In June 2014, the Task Force selected Tenet as its preferred partner. In July 2014, the Saint Mary's Board of Directors selected Tenet as its preferred partner. Exhibit C includes the redacted Board Task Force minutes.

A number of Exhibits in this Application demonstrate the extensive due diligence undertaken by Saint Mary's. Exhibit D is an Affiliation Timeline prepared by H2C that outlines the history of the multiple search processes. Exhibit E is a profile of Tenet and a summary of Tenet's Catholic hospital experience. Exhibit F is a high-level comparison of offers between Tenet and Party 2 and the guiding principles of affiliation. Exhibit G is a more detailed comparison of offers between Tenet and Party 2
In addition, please see the response to Question 6 regarding the Fairness Opinion that Saint Mary's has received from Principle Valuation, LLC.

5. **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 SMHS, Tenet, 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 SMHS and Tenet defined "conflict of interest" for purposes of the response to this question.**

Conflict of Interest/Financial Disclosure forms (the "Disclosure") were prepared and disseminated to (i) members of the board of directors of Saint Mary's and the Hospital, (ii) experts, and (iii) Saint Mary's and Tenet senior executives with managerial responsibilities who have direct involvement in the proposed transaction. The Disclosure required responses with respect to any financial interests, beneficial interests 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 an 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 Saint Mary's are attached as Exhibit I[1]. The completed Disclosures for Tenet are attached as Exhibit J. 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 of which accompanies the Tenet Disclosures.

Several of the Saint Mary's and Hospital Board members are physicians employed by the Hospital or an affiliate, and the Hospital's CEO is a voting member of both the Saint Mary's and the Hospital Boards.

[1] Please note that Exhibit H was reserved and not utilized.

6. **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 SMHS'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.**

   Saint Mary's engaged Principle Valuation, LLC ("Principle") to perform the valuation of Saint Mary's. Saint Mary's Board Members believe Principle staff members have unique knowledge and experience in the Waterbury market, as well as in non-profit/for-profit transactions, which resulted in a time and cost efficient engagement. Principle's qualifications and conflict disclosure are fully articulated in the Request for Proposal response included as Exhibit K. Principle's role in this transaction is limited to performing the fairness assessment and its commission is a flat, non-contingent fee. In determining whether the purchase consideration is fair from a financial point of view, Principle has compared the financial rights and responsibilities that currently are held by Saint Mary's with the proposed sales terms. In deriving their "Fairness Opinion," Principle considered the value of the assets transferred against the value of the benefits to be received from a financial point of view. Principle's Valuation is included as Exhibit L.

7. **Provide an assessment of whether the transaction will place SMHS's assets, including but not limited to Saint Mary's Hospital itself, 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.**

   Saint Mary's assets will not be placed at unreasonable risk. Instead, Saint Mary's assets will be strengthened with the acquisition by Tenet. Tenet is a $17 billion revenue healthcare organization and has the financial capacity to provide the capital necessary for this transaction. Please see Exhibit M for Tenet's 2013 10-K and Exhibit N for Tenet's 2014 2nd quarter 10-Q, which demonstrate Tenet's strong financial position. Please also see the response of Principle to issue 6 at page 5 of the Fairness Evaluation (Exhibit L) for additional discussion.

8. **Provide an assessment of whether any management contracts to be entered into are for reasonable fair market value. Provide copies of the management contracts and of all documents and statements, financial and otherwise, in support of the fair market 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.**

   The New SM Hospital will not be entering into any management contracts.

9. Describe the charitable entity to which the fair market value of SMHS'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.

DESCRIPTION OF THE FOUNDATION

Saint Mary's Hospital Foundation, Inc. (previously defined as the "Foundation") will continue as a separate tax-exempt 501(c)(3) organization and will receive the remaining proceeds following the completion of the transaction. The main purpose of the Foundation will be to support charitable health-related activities in the community in addition to those that will continue to be provided by the New SM Hospital in accordance with the community benefit standards.

THE FUNDING OF THE FOUNDATION

The Foundation will receive the remaining proceeds from the transaction, after provisions have been made for funding of the Hospital's pension liability in accordance with the requirements of ERISA and after settling any long-term debt obligations. The assets of the Foundation will also include short term investments, marketable securities and certain assets whose use is limited by donors and/or held in trust. The Foundation may also apply for grants from governmental and private sources in order to collaborate with other entities in support of community health needs. As previously noted, at the time of the closing, the Foundation will retain approximately $135,983,000.

THE STRUCTURE OF THE FOUNDATION

The Foundation's articles of incorporation and by-laws will be modified to reflect the changes necessitated by the transaction, including independence from the New SM Hospital and a new purpose focused on community health versus hospital philanthropy. A strategic planning process will be completed in order to define the new mission and work plan for the Foundation.

GOVERNANCE

The initial Foundation Board will be appointed by the Saint Mary's Board of Directors and will be comprised of community members currently serving on either the Hospital and/or Foundation Board. The Archbishop or his designee will participate on the Foundation Board. The initial board members will serve a three-year term, after which the Board will become self-perpetuating and, as noted, will complete a strategic planning process to define the specific objectives and areas of focus for the Foundation.

THE CHARITABLE PURPOSE

The charitable purpose of the Foundation will differ from its current mission, which is to advance the purposes of the Hospital through the solicitation of funds. A strategic planning

process following the Closing will result in the development of a new mission. The new mission will be focused on supporting community health needs and will no longer provide charitable support to the Hospital.

10. Identify any and all assets of SMHS that are subject to a charitable use restriction imposed by a donor and the intended handling of those assets as a result of the Asset Purchase. Please provide a listing of these assets in Microsoft Excel format. Also, please provide copies of the original gift instruments for each gift identified.

Following the Asset Purchase, the Foundation will remain in existence, with new corporate and charitable purposes to be determined by a new Board of Directors. Except as to any fund for which the donor specified a gift-over, the funds described herein will be retained by the Foundation to be re-directed to charitable purposes consistent with the intent of the donors, as directed by the Attorney General.

SUMMARY OF THE FOUNDATION'S ASSETS

The assets of the Foundation are segregated into three classifications. Assets of each classification as of May 31, 2014, are as follows:

Unrestricted Funds	
Board Restricted	$ 153,000
General Unrestricted	$1,856,000
Funds Restricted As To Use	
Foundation	$1,813,000
CUPMIFA	$ 375,000
Endowment Fund	$ 968,000

The information below provides an overview of the Unrestricted Funds, the Funds Restricted As To Use, and the Endowment Fund. Original documentation regarding the donor restricted funds is contained in the binders (Exhibit O[2] - the Saint Mary's Foundation Binders) submitted with this Application.

Unrestricted Fund

The Unrestricted Funds were donated through special events, annual fund appeals, memorials, and direct donations by generous donors for use by the Hospital to improve patient care. In response to requests from the Hospital, the Foundation's Board of Directors has authorized distributions from the Unrestricted Funds. The Unrestricted Funds include the Board Restricted Fund, which consists of contributions by individual members of the various boards of the Hospital donated over several years through annual board appeals. The

[2] Please note that one bulk file hard copy set of Foundation binders was given to the Attorney General, and one bulk file hard copy set of Foundation binders was given to OHCA.

Foundation's Board of Directors has the authority to expend the funds in the Board Restricted Fund on programs and services that advance the purpose of the Hospital.

Funds Restricted As To Use

The Funds Restricted As To Use are individual funds that were given by donors that contained restrictions as to the use of the funds. The source of the funds includes gifts, donations, special events, bequests, and annual appeals. The total number and balance of each fund fluctuates monthly depending on earnings and withdrawals. The funds are used in accordance with the donors' restrictions.

Currently, the Foundation has a total of 68 Funds Restricted As To Use. These funds are organized in 11 categories based on the intended use of the fund. The categories are Cardiology, Pediatric and Family Services, Emergency Department, Department of Surgery, Nursing Departments, Clinical Departments, Non-Clinical Departments, Medical/Surgical Education, Special Funds, Scholarship Funds, and Education Funds. As of May 31, 2014, the balance for all of these funds was $1,812,627. A summary chart contained in Exhibit P outlines each of the funds, the fund balance as of May 31, 2014, and a brief description of the use of the funds.

The Funds Restricted As To Use also includes funds under the Connecticut Uniform Prudent Management of Institutional Funds Act ("CUPMIFA"), which represents earnings on the Endowment Fund.

A description of the funds by category follows.

Cardiology

There are four funds under the heading of Cardiology. As of May 31, 2014, the fund balance was $363,004. The funds in this category include Cardiology/Cardiac Care (Exhibit O, Binder 1, Section A2), Herman Weisman/Telemetry (Exhibit O, Binder 1, Section A3), J. Robert Anthony Fund (Exhibit O, Binder 1, Section A4), and Medical Equipment Fund (Exhibit O, Binder 1, Section A5).

Pediatric and Family Services

There are 16 funds under the heading of Pediatric and Family Services. As of May 31, 2014, the fund balance was $390,592. Of these funds, nine were grants. As of May 31, 2014, the balance for these grants was $90,052. The grants include, Pediatric Services/EKG (Exhibit O, Binder 1, Section B3) to purchase a children's EKG machine, Medical Home (Exhibit O, Binder 1, Section B4), Touchpoints Program (Exhibit O, Binder 1, Section B5), Childhood Asthma Prevention (Exhibit O, Binder 1, Section B7) from the Neighborhood Assistance Act for asthma prevention, Children's Behavioral Health Screenings (Exhibit O, Binder 1, Section B8), Childhood Obesity from the

American Heart Association. (Exhibit O, Binder 4, Section L2), Reach Out and Read Program (Exhibit O, Binder 1, Section B14), and Teen Grief Support Groups (Exhibit O, Binder 1, Section B15) from the J. Walton Bissell Foundation. All of the grants listed above will be utilized in accordance with the terms set forth in the respective agreements. The remaining funds in this category include Pediatric Services Carbonari (Exhibit O, Binder 1, Section B1), Pediatric and Family Services Operating (Exhibit O, Binder 1, Section B6), Gorman Asthma Fund (Exhibit O, Binder 1, Section B13), Family Health Center Educational Fund (Exhibit O, Binder 1, Section B10), Family Health Center Hypertension (Exhibit O, Binder 1, Section B11), Special Needs fund (Exhibit O, Binder 4, L2), Gala Funds from 2012 (Exhibit O, Binder 4, Section L2), and Family Rescue (Exhibit O, Binder 1, Section B9).

Emergency Department

There is one fund under the heading of Emergency Department. As of May 31, 2014, the fund balance was $3,373. The fund in this category is Emergency Department Services (Exhibit O, Binder 1, Section C1).

Department of Surgery

There are three funds under the heading of Department of Surgery. As of May 31, 2014, the fund balance was $405,398. The funds in this category include daVinci Robotic Surgery Program (Exhibit O, Binder 1, Section D1), Same Day Surgery (Exhibit O, Binder 1, Section D2), and Surgical Services-Gala (Exhibit O, Binder 1, Section D3).

Nursing Departments

There are seven funds under the heading of Nursing Departments. As of May 31, 2014, the fund balance was $95,245. The funds in this category include Birthing Center (Exhibit O, Binder 2, Section E1), Intensive Care (Exhibit O, Binder 2, Section E2), Maternity/Women & Infants (Exhibit O, Binder 2, Section E3), Women & Infants Neonatal (Exhibit O, Binder 2, Section E4), O'Brien 7 (Exhibit O, Binder 2, Section E5), Pediatrics (Exhibit O, Binder 2, Section E6), Sacred Heart 5 (Exhibit O, Binder 4, Section L5), and Xavier 3 (Exhibit O, Binder 2, Section E7).

Clinical Departments

There are eight funds under the heading of Clinical Departments. As of May 31, 2014, the fund balance was $43,880. Of these funds, three are grants. As of May 31, 2014, the remaining balance of the grants was $24,571. The grants include Breast Center (Exhibit O, Binder 2, Section F1) from the Susan G. Komen Foundation to be used for breast biopsies, computer scanner, translation software, Cyracom language line, mammograms and Clinical Breast Exams; Dental (Exhibit O, Binder 2, Section F2) to be used to purchase dental equipment for dental clinic or dental room at Children's Health Center; and Naugatuck Urgent Care (Exhibit O, Binder 2, Section F6) from the Connecticut Community Foundation to be used to purchase equipment. The remaining funds in this

category include Endoscopy/Gastro (Exhibit O, Binder 2, Section F3), Hospice Room Fund (Exhibit O, Binder 2, Section F5), Oncology (Exhibit O, Binder 2, Section F4), Pulmonary/Respiratory (Exhibit O, Binder 2, Section F7), Prospect Walk in (Exhibit O, Binder 4, Section L4), and Wound Care (Exhibit O, Binder 2, Section F8).

Non-Clinical Departments

There are five funds under the heading of Non-Clinical Departments. As of May 31, 2014, the fund balance was $31,823. The funds in this category include Child Development Center (Exhibit O, Binder 2, Section G1), Fitness Center Fund (Exhibit O, Binder 2, Section G2), Library (Exhibit O, Binder 2, Section G4), Pastoral Care (Exhibit O, Binder 2, Section G6), and Lifeline (Exhibit O, Binder 2, Section G5).

Medical/Surgical Education

There are six funds under the heading of Medical/Surgical Education. As of May 31, 2014, the fund balance was $177,433. Of these funds, three are grants. As of May 31, 2014, the balance of the grants was $132,077. The grants include Residency Program (Exhibit O, Binder 3, Section H4) from money raised at the Gala to be used for Research Day; Dudrick Surgical Education & Research Fund (Exhibit O, Binder 3, Section H5) to be used for surgical residents; and Dr. William Finklestein-Research Fellowship for Yale Resident (Exhibit O, Binder 3, Section H6) from the Estate of Dr. Finklestein for resident research projects. The remaining funds in this category include Asghar Rastegar Research Fellowship (Exhibit O, Binder 3, Section H1), Department of Medicine (Exhibit O, Binder 3, Section H2), and Medical & Nursing Education (Exhibit O, Binder 3, Section H3).

Special Funds

There are 10 funds listed under the heading of Special Funds. As of May 31, 2014, the fund balance was $169,572. The funds in this category include Breast Health (Exhibit O, Binder 3, Section I1), Board of Directors (Exhibit O, Binder 3, Section I3), Building Fund (Exhibit O, Binder 3, Section I4), Employee Crisis (Exhibit O, Binder 3, Section I5), Enrichment Grant Program (Exhibit O, Binder 3, Section I6), Sisters of Saint Joseph (Exhibit O, Binder 3, Section I9), Cancer Research (Exhibit O, Binder 4, Section L5), Dr. Finklestein-Restoration & Archival Work (Exhibit O, Binder 3, Section I10), Antiphospholipid Syndrome (Exhibit O, Binder 4, Section L1), Archbishop Mansell Champion Dinner 2011 (Exhibit O, Binder 4, Section L1), and Day of Parking (Exhibit O, Binder 4, Section L1).

Scholarship Funds

There are five funds listed under the heading of Scholarship Funds. as of May 31, 2014, the fund balance was $118,665. The funds in this category include The Charlotte Desmarais Scholarship (Exhibit O, Binder 3, Section J1), Mimi Rowe Scholarships (Exhibit O, Binder 3, Section J3), Ryan Largay Memorial-Nursing Scholarships (Exhibit

O, Binder 4, Section L3), and School of Nursing Alumni (Exhibit O, Binder 3, Section J4).

Education Funds

There are three funds listed under the heading of Education Funds. As of May 31, 2014, the fund balance was $16,568. Of these funds, one is a grant. As of May 31, 2014, the balance of the grant is $1,236. The grant includes Oncology (Exhibit O, Binder 3, Section K2) to be used for oncology staff education. The remaining funds in this category include Education (Miscellaneous & Nonspecific) (Exhibit O, Binder 3, Section K1) and Nursing Education (Exhibit O, Binder 3, Section K3).

Endowment Fund

The Endowment Fund was established by the Board of Directors of the May Fund Corporation. The Board of Directors of the May Fund Corporation voted to establish the Endowment Fund with the intent of growing the fund through future contributions.

As of May 31, 2014, the Foundation's Endowment Fund had a balance of $967,889. The majority of the funds in this account represents distributions from three estates – the first in the amount of $79,294.82 from the Estate of James Garvey in 1995, the second in the amount of $477,888.86 from the Estate of Helen L Garvey in 2006, and the third in the amount of $150,000 from the Estate of William Finklestein, M.D. in 2005 The remaining balance of $260,705 consists of interest and additional funds transferred into the Endowment Fund by the Board of Directors of the original May Fund Corporation.

The Foundation has interpreted 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. The Foundation classifies as permanently restricted net assets (a) the original value of the gift donated to the 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 to the Endowment Fund. The remaining portion of the 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 Foundation in a manner consistent with the standard of prudence prescribed by CUPMIFA.

SAINT MARY'S HOSPITAL RESTRICTED FUNDS

The assets are segregated into two classifications. As of May 31, 2014, the assets of each classification are as follows:

Funds Restricted As To Use	
HLRCC[3]	$124,000
Third Party Trust	$15,900,000

FUNDS RESTRICTED AS TO USE

Harold Leever Regional Cancer Center

The Hospital has a 50% interest in the Harold Leever Regional Cancer Center ("HLRCC") and records an accounting interest in the funds of approximately $124,000. Investment and management of the funds is not handled by the Hospital.

THIRD PARTY TRUST

Hellman Trust

The Trust was established pursuant to Section E of Article Fourth of the Last Will and Testament of Charles M. Hellman. The Hospital is entitled to receive one-half of the yearly income of the Trust, semiannually, to be used "as it may deem for the best interests of [the H]ospital." The Waterbury Hospital, Inc. is entitled to receive the other one-half of the yearly income of the Trust, semiannually. Distributions of principal are not permitted. The current total fair market value of the Trust principal is approximately $31,800,000. The distributions received by the Hospital from the Trust are unrestricted.

The Last Will and Testament of Charles M. Hellman provides that, in the event that the Hospital goes out of existence (or is merged with another hospital to form a corporation that does not carry out the purposes of the hospital so merged), the entire income of the Trust is to be paid to the remaining hospital. If both the Hospital and The Waterbury Hospital, Inc. go out of existence (or are merged with another hospital to form a corporation that does not carry out the purposes of the hospital so merged), the income is to be paid out to Meriden Hospital; or, if Meriden Hospital goes out of existence (or is merged with another hospital to form a corporation that does not carry out the purposes of the hospital so merged), the income shall be paid to other charitable, religious and eleemosynary corporations in Waterbury which carry out the principles and teachings of the Hospital and The Waterbury Hospital, Inc., as the Trustees deem advisable.

[3] Harold Leever Regional Cancer Center

11. **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 SMHS.**

Please see Exhibit F which contains the high level comparison of offers to Saint Mary's from Tenet and "Party 2." Also attached as Exhibit P is correspondence from two additional parties (not "Party 2").

12. **Provide a copy of a fairness evaluation/opinion 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/opinion.**

Principle Valuation, LLC's Fairness Opinion has been included as Exhibit L.

13. **Describe the proposed corporate relationship between the New SM 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 contemplated ownership of VHS Waterbury Health System, LLC, and the New SM Hospital.**

The New SM Hospital will be wholly owned by a subsidiary of Tenet. Greater Waterbury Health Network will own 20% of the proposed VHS Waterbury Health System, LLC and a subsidiary of Tenet will own the other 80%. There is no other proposed formal corporate relationship between the two entities.

14. **Describe the proposed corporate relationship between the New SM Hospital and the proposed VHS Eastern Connecticut 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 Eastern Connecticut Health System, LLC, and the New SM Hospital.**

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

15. Describe the proposed corporate relationship between the New SM 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 contemplated ownership of VHS Bristol Health System, LLC, and the New SM Hospital.

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 the New SM Hospital and VHS Bristol Health System, LLC.

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

The informal hearing for the public took place on Monday, July 28, 2014, at 5:00 PM in the Saint Mary's Hospital Medical Dental Conference Center Auditorium. The transcript is included as Exhibit Q.

17. Describe the proposed corporate relationship between the New SM Hospital and the proposed partnership between Yale New Haven Health System and Tenet ("YNHHS/Tenet Partnership"). Please also comment on whether there is or is not any planned relationship between the New SM Hospital and the YNHHS/Tenet Partnership or any entity formed as a result of the YNHHS/Tenet Partnership, and the nature of such partnership.

It is the intention of VHS of Connecticut, LLC to transfer its ownership interest post-closing to an 80-20 joint venture between a Tenet affiliate and YNHHS. However, the closing of the transaction is not contingent upon the ability of Tenet to effect such transfer post-closing.

18. Explain how SMHS determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for St. Mary's Hospital ("Hospital") (provide discussion on history and time-line).

Saint Mary's has been searching for a solution to meet the ever-increasing demands of providing high quality health care to the residents of the greater Waterbury area for the last ten years. While it has not yet risen to a crisis situation, the leaders at Saint Mary's recognize that the changes that are evolving in the health care market place are putting additional strains on Saint Mary's system (specifically the budget), and that it will become even more difficult as time goes on. While expenses keep rising, reimbursement from the government keeps shrinking (*see* Exhibit R). Since 73% of Saint Mary's patients are covered by either state government programs or the federal Medicare program, a reduction in government funding diminishes the prospects for moving forward to meet these new demands without an infusion of capital in order to revamp the system.

In addition, there are many new programs that Saint Mary's has been eager to implement: some in accordance with the Community Health Needs Assessment that was completed by a large group within the Waterbury community recently, and others involving maintaining and improving the Hospital's physical plant and technological capabilities, as well as reduction of debt and payment of unfunded pension liabilities. An Asset Purchase provides the capital and best practices that are available from a large healthcare system like Tenet that will allow these and other programs to become a reality. Specifically, the clear public needs for Saint Mary's to embrace the proposal from Tenet are as follows:

- To take advantage of the financial resources of a large system such as Tenet, which will allow the New SM Hospital to continue to provide quality health care services in the greater Waterbury area and be able to expand those services by making them more accessible to a greater number of people;

- To have the resources necessary to develop more preventive and primary care services in the greater Waterbury area so that patients in the New SM Hospital's service area stay healthy, including the resources to implement the programs identified in the Community Health Needs Assessment;

- To meet the demands of the 2010 Patient Protection and Affordable Care Act, which will require an emphasis on value rather than volume in terms of reimbursement for health care services. This will be accomplished by raising the quality of services even higher than now exists as physicians and hospitals (and all caregivers along the continuum) work together with the patient at the center of that care;

- To create efficiencies that result from being part of a system as large as Tenet, so that health resources are not wasted, which will also enable more patients to be served;

- To have access to capital that only a large system like Tenet can offer, so that interest rates are lower for borrowing, and access to capital is easier;

- To have the financial security to know that the employees who are retired from the Hospital, and the employees who are currently working at the Hospital, will have the pension that they have been promised; and

- The knowledge that even though Tenet is a for-profit company, it has agreed to abide by the "community benefits standards" that non-profit hospitals are required to follow, and that Tenet has also agreed that the New SM Hospital will follow the Directives.

19. 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 for the first three years post-approval of the Asset Purchase. Provide an explanation for each change.

Saint Mary's services are listed below:

Cardiovascular services
- Diagnostic catheterization
- Interventional Cardiology- Angioplasty
- Pacemaker Implantation
- Cardiac surgery
- Medical Cardiology
- Telemetry Monitoring
- Cardiovascular unit for post interventional patients

Surgical services
- General surgery
- Robotic surgery
- Bariatric surgery
- Neurosurgery
- Orthopedic surgery
- Other surgical specialties including colorectal, gynecology, urology, gastroenterology, otolaryngology, thoracic, vascular, breast and oncology
- Ambulatory surgery (on hospital main campus as well as off-site at Naugatuck Valley Surgical Center)

Medical services
- General Adult Medicine
- Pulmonary
- Neurology
- Oncology/Hematology
- Endocrinology
- Critical Care Medicine
- Other medical specialties covering nephrology, gynecology, urology, gastroenterology, rheumatology

Women and Infant services
- Obstetrics
- Neonatology (Level 2 NICU)

Behavioral Health

- Adult and adolescent inpatient Behavioral Health services
- Outpatient Mental Health Clinic and Substance Abuse Treatment Center

Emergency Department

- Emergency Department including a Level 2 Trauma Center
- Designated a Primary Stroke Center (by Connecticut Department of Public Health)

Imaging Services

- CT Scanning
- Digital mammography
- DEXA bone density scanning
- Nuclear Medicine
- Ultrasound
- MRI
- X-ray

Interventional Radiology

- Angiography
- Biopsies
- Stent Placement

Breast Care

- Stereotactic breast biopsies
- Breast ultrasound

Other Outpatient Programs

- Two Urgent Care Centers located in Naugatuck and Wolcott
- Accredited Sleep Disorders Center located in Wolcott and Waterbury
- Physical and Occupational Therapy
- Cardiac and Pulmonary Rehabilitation
- Pulmonary Function Testing
- Endoscopy Services
- Dental Clinic
- Family Health Center
- Cardiac Diagnostic Testing
  - Nuclear Stress Testing
  - Echocardiography
  - EKG
  - Holter monitoring/event and loop recording
- Laboratory Services

Services are provided on the Hospital's main campus as well as outpatient locations throughout the service area. For a listing of outpatient services by locations, please see Exhibit S. For a listing of Franklin Medical Group, P.C. primary care and specialty care locations please see the response to Question 3.

Saint Mary's currently leases space on the main campus to two organizations to provide inpatient services. Inpatient pediatric services are provided by Connecticut Children's Medical Center ("CCMC") and inpatient hospice services are provided by VITAS.

All health care services, including those provided by CCMC and VITAS, will continue to be offered at their current locations.

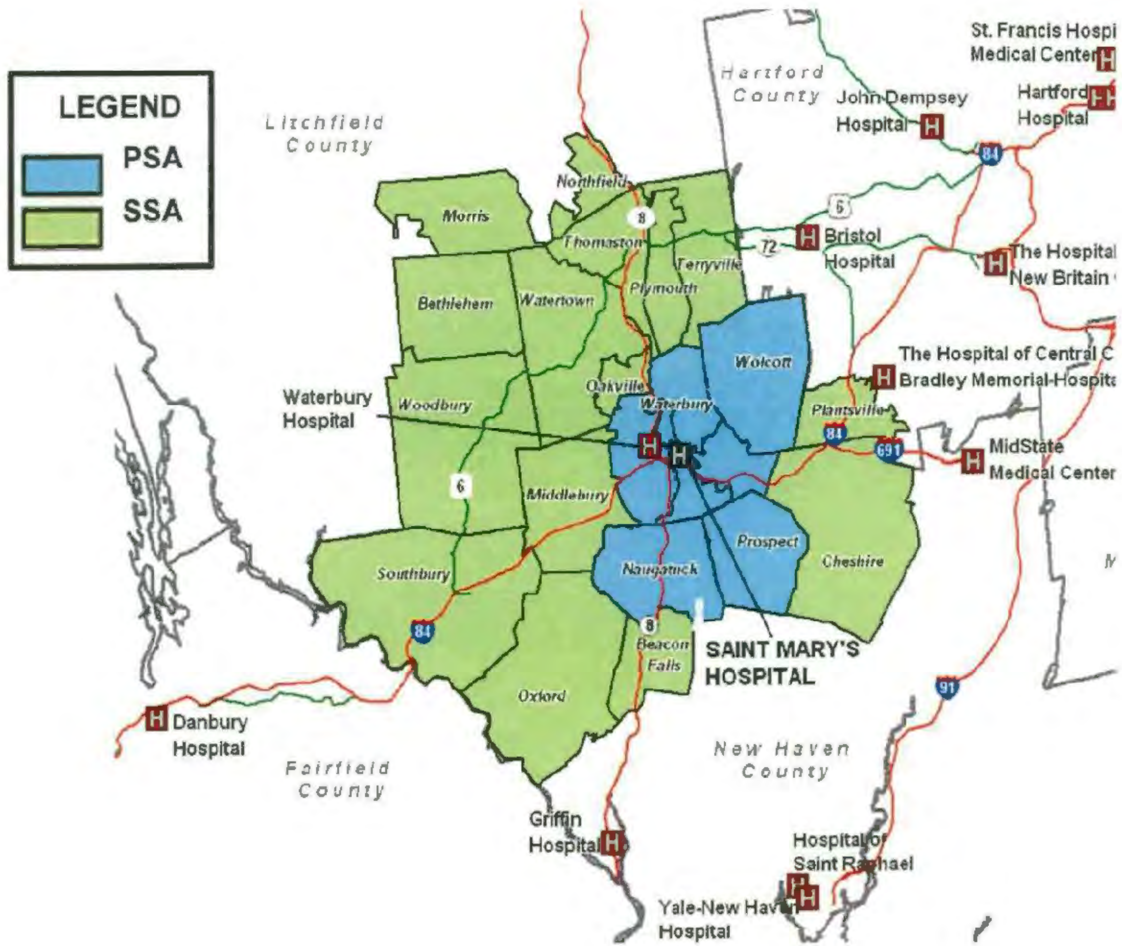
At this time, there are no changes planned, however, as noted in the Applicants' response to Question 22, Tenet's common ownership of hospitals in Waterbury provides an opportunity to coordinate care in a manner that will improve access, enhance the quality of care provided and decrease costs.

20. Describe the existing populations served by the Hospital and how the Asset Purchase will affect these populations. Include demographic information.

SERVICE AREA

Saint Mary's has an 18-town service area. The primary service area ("PSA") consists of Naugatuck, Prospect, Waterbury and Wolcott. The secondary service area ("SSA") includes Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Oxford, Plantsville, Plymouth, Southbury, Southington (Plantsville area), Terryville, Thomaston, Watertown (including Oakville) and Woodbury. Please see Figure 1 for a map of the service area.

Figure 1: Saint Mary's Health System Service Area



Service Area Demographic Data

Table 4 provides a summary of the population of the service area from 2000 projected to 2020. The City of Waterbury (a PSA for the Hospital) is projected to experience a 4.9% increase in population from 2010 to 2020. A population increase of 5.5% is projected for the 12 town secondary service area.

Waterbury is the largest municipality in the service area. In 2010, it accounted for 66% of the population in the primary service area and 32% of the population in the total service area.

Table 4: Total Population 2000 – 2020

Town	2000	2010	2020
Naugatuck	30,989	31,746	32,877
Prospect	8,707	9,282	9,864
Waterbury	107,271	109,941	115,128
Wolcott	15,215	16,446	17,821
Primary Service Area	**162,182**	**167,415**	**175,690**
Beacon Falls	5,246	5,909	6,648
Bethlehem	3,422	3,595	3,711
Cheshire	28,543	29,200	29,120
Middlebury	6,451	7,390	8,471
Morris	2,301	2,461	2,460
Oxford	9,821	12,192	14,714
Plymouth	11,634	12,213	12,789
Southbury	18,567	19,690	20,480
Southington	39,728	42,491	45,136
Thomaston	7,503	7,873	8,112
Watertown	21,661	22,522	23,020
Woodbury	9,198	9,909	10,395
Secondary Service Area	**164,075**	**175,445**	**185,056**
Total Service Area	**326,257**	**342,860**	**360,746**

Source: Connecticut Economic Resource Center, Inc. (CERC, 2013). Oakville data is included with Watertown and Terryville data is included with Plymouth.

Tables 5 and 6 describe the age distribution in the primary and secondary service areas by town. The age distribution of the service areas is also compared to that of the state.

Table 5: Age Distribution Primary Service Area

Town	0-4	5-17	18-24	25-49	50-64	65+
Naugatuck	6.7%	16.3%	7.7%	37.2%	19.2%	13.0%
Prospect	5.3%	16.1%	7.1%	34.2%	22.4%	15.0%
Waterbury	7.5%	18.6%	9.7%	34.6%	17.0%	12.6%
Wolcott	3.6%	19.3%	8.7%	32.0%	21.2%	15.3%
PSA	**6.8%**	**18.1%**	**9.0%**	**34.8%**	**18.1%**	**13.1%**
Connecticut	**6%**	**17%**	**9%**	**34%**	**20%**	**14%**

Source: CERC, 2013

Table 6: Age Distribution Secondary Service Area

Town	0-4	5-17	18-24	25-49	50-64	65+
Beacon Falls	6.2%	16.9%	7.5%	32.6%	24.8%	12.1%
Bethlehem	4.7%	15.8%	7.1%	27.8%	27.0%	17.6%
Cheshire	4.5%	19.2%	9.0%	33.7%	20.2%	13.5%
Middlebury	3.8%	19.9%	5.7%	30.9%	23.6%	16.2%
Morris	3.1%	17.2%	7.7%	30.1%	25.9%	15.9%
Oxford	3.8%	13.0%	13.6 %	20.4%	12.0%	37.2%
Plymouth	5.0%	17.9%	8.2%	34.5%	22.4%	12.0%
Southbury	3.8%	15.7%	5.9%	24.2%	23.1%	27.3%
Southington	4.8%	17.0%	6.6%	31.6%	22.4%	17.5%
Thomaston	3.5%	17.5%	7.0%	36.2%	22.4%	13.4%
Watertown	4.7%	16.7%	7.8%	31.7%	22.2%	16.8%
Woodbury	4.0%	18.0%	5.1%	28.2%	28.5%	16.1%
SSA	**4.4%**	**17.0%**	**7.8%**	**30.1%**	**21.7%**	**18.9%**
Connecticut	**6%**	**17%**	**9%**	**34%**	**20%**	**14%**

Source: CERC,2013. Oakville data is included with Watertown and Terryville data is included with Plymouth.

Table 7 presents socio-economic data for the primary and secondary service area in comparison to the State. The data for the total service area reveals a diverse population ranging from urban to suburban to rural. While some of the communities are composed of an older, more affluent population, Waterbury is an economically distressed community with 20% of its population below the poverty level. The significant levels of poverty are reflected in the patient mix treated at the Hospital. In Fiscal Year 2014 Year to Date (October 1, 2013 – April 30, 2014), 28.6% of patients discharged from the Hospital were Medicaid recipients.

Central Waterbury has been designated by the Health Resources and Services Administration as a Health Professional Shortage Area as well as a Medically Underserved Area and Medically Underserved Population. The Hospital serves as a safety net hospital to this region. This proposal provides the necessary financial resources and cost savings opportunities to ensure that health care services will remain available to the vulnerable population in the Hospital's service area. The proposal will ensure a more secure financial future so that the Hospital can continue to provide essential health services to the community.

Table 7: Socio/Economic Data

Town	Poverty Rate*	Household Income*	Unemployment rate**	Median Age*
Primary Service Area				
Naugatuck	8.5%	$63,414	10.1%	38
Prospect	2.4%	$93,631	7.7%	44
Waterbury	20.6%	$41,499	13.1%	35
Wolcott	3.3%	$80,529	8.7%	43
Secondary Service Area				
Beacon Falls	3.5%	$80,182	8.0%	47
Bethlehem	3.5%	$86,891	6.7%	40
Cheshire	2.5%	$109,535	6.5%	40
Middlebury	2.7%	$99,679	6.6%	44
Morris	4.8%	$87,970	6.7%	46
Oxford	1.7%	$111,122	6.3%	43
Plymouth	5.7%	$74,317	9.5%	40
Southbury	5.2%	$72,177	6.9%	50
Southington	3.5%	$77,112	7.1%	44
Thomaston	2.8%	$64,982	8.5%	43
Watertown	3.4%	$81,203	8.3%	45
Woodbury	4.7%	$86,802	6.3%	46
Connecticut	**9.5%**	**$62,497**	**8.4%**	**40**

**2011*

*** 2012*

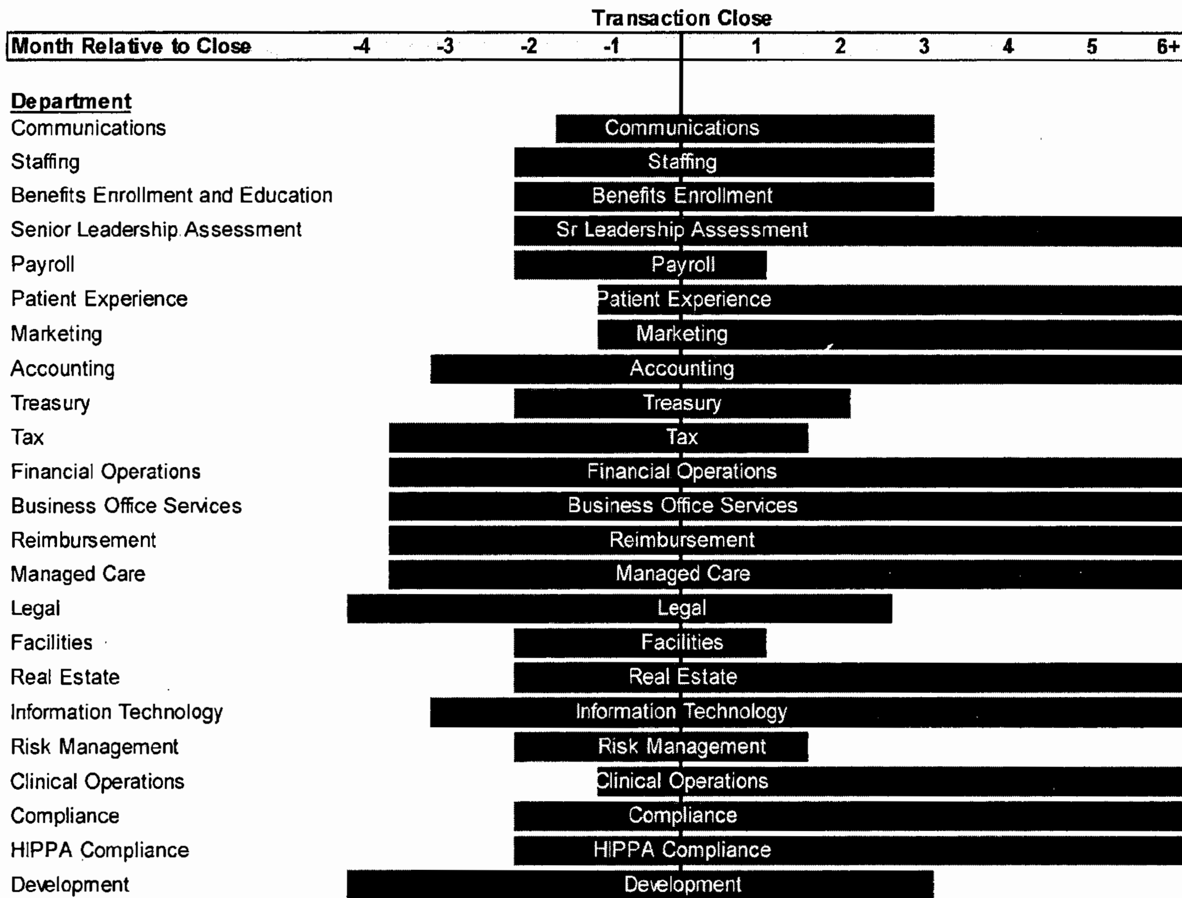
Source: CREC 2013. Oakville data is included with Watertown and Terryville data is included with Plymouth.

After the proposed Asset Purchase is completed, the existing populations that the Hospital serves will continue to have access to the same or higher quality services than Saint Mary's currently provides.

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

The approach to the transition plan is best segregated into three phases of implementation: (1) execution of immediate cost efficiencies, (2) clinical efficiencies, and (3) deployment of a strategic capital plan. Immediate cost efficiencies represent benefits the New SM Hospital will receive from joining a national organization. These cost efficiencies are presented in the financial projections included as Exhibit Z 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.

Figure 2: 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 the New SM Hospital.

22. Understanding the proposed common ownership of the hospitals in Waterbury with Tenet, how will care be coordinated in the Waterbury region? Please explain in detail and provide any written plans documenting this coordinated approach to care for the patient population served.

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 Waterbury 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. Both hospitals and Tenet believe that the hospitals working more collaboratively in

a common ownership model affords a tremendous opportunity to coordinate care and provide a higher quality of care and a more cost effective healthcare delivery system for the Waterbury region. To that end, Tenet is evaluating the services provided at both hospitals to identify how care can be coordinated in the Waterbury region in a manner that will improve access, enhance the quality of care provided and decrease cost.

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

The Asset Purchase Agreement between Saint Mary's and Tenet 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[4]. The Saint Mary's/Tenet transaction 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).

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[4] http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

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 the New SM Hospital in developing economies of scale when purchasing supplies and services, and will also improve access to capital. These factors, in turn will allow the New SM Hospital to improve the quality of care that is required by the 2010 Patient Protection and Affordable Care Act ("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 the New SM Hospital to meet its financial obligations, make needed capital improvements, acquire new technology and continue to be a safety net provider in the Greater Waterbury region.

By entering into the proposed Asset Purchase Agreement with Tenet, the New SM Hospital will be able to fulfill Saint Mary's obligations, including retiring its debt, and funding its pension plan. As a result, the New SM Hospital 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, the New SM Hospital will be able to improve its 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). Tenet will provide the necessary funding to develop a HITE and electronic health records ("EHRs"). Paper records will be replaced by EHRs to report patients' diagnostic data. Opportunities to regionalize the health care delivery system in the greater Waterbury area will be enhanced, building upon existing initiatives such as the Heart Center and the Cancer Center. The size of the Tenet system will provide the New SM Hospital with regional and national scale leverage and 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 the New SM Hospital'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.

24. Reference is made to the Greater Waterbury Health Improvement Partnership's Community Health Needs Assessment Final Summary Report dated September 2013 and the prioritized health issues identified at page 3. Please explain how the New SM Hospital will address each of these issues and specifically how the Asset Purchase will aid in attempting to remove cost of care as a barrier to health care access for Waterbury-area residents.

The Hospital led the formation of the Greater Waterbury Health Improvement Partnership ("GWHIP") in 2012. GWHIP brought together local non-profits that pooled resources in order to conduct a comprehensive Community Health Needs Assessment ("CHNA"). GWHIP includes the Hospital, Waterbury Hospital, the City of Waterbury Department of Health, the Connecticut Community Foundation, StayWell Health Center, the United Way of Greater Waterbury and other community partners.

As part of the CHNA, GWHIP hosted a Prioritization Session that included 40 representatives from local non-profits and government agencies. The Prioritization Session, which took place in 2013, included a review of the CHNA research as well as a group process for selecting community health priorities. The group voted on priorities and selected four areas to prioritize: (1) Access to Care; (2) Mental Health and Substance Abuse; (3) Obesity and Chronic Disease; and (4) Tobacco Use.

The Hospital developed an Implementation Strategy that addresses the four community health priorities. The Hospital's Board of Directors met on September 12, 2013, to review the findings of the CHNA and the Implementation Strategy. The Implementation Strategy is attached as Exhibit T. On September 12, 2013, the Boards of Directors of Saint Mary's and the Hospital voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives (*see* Exhibit U).

The New SM Hospital will continue to support this Implementation Strategy which is being rolled out over three years. The current Implementation Strategy initiatives by community health priority area include:

Access to Care Initiatives

- Collaborating with Access Health CT to help residents gain access to health insurance. The Hospital hosted several enrollment fairs during the 2013 – 2014 enrollment period.
- Evaluating opportunities to improve access to primary and urgent care. The Hospital is working with StayWell Health Center to transition ownership and operation of the

Children's Health Center ("CHC"). CHC patients will now be able to access StayWell's extensive offerings of health and social services.

- Developing nurse navigator programs to improve access to primary care and behavioral health. In 2013, the Hospital implemented a nurse navigator program in the Emergency Department ("ED"). The nurse navigator reviews between 60 and 200 patient records per week. The navigator contacts many of these patients to coordinate follow-up care and connect patients with other resources.
- Educating health care providers on resources for uninsured/underinsured and low income patients.
- Providing free screenings for uninsured and underinsured patients. For example, the Hospital provides free breast and cervical cancer screenings, diagnostic and treatment referral services through a Connecticut Department of Health grant.

Mental Health and Substance Abuse Initiatives

- Evaluating options to enhance the Behavioral Health unit in the ED to better meet patient needs. A "Super Track" initiative is underway in the ED. This initiative has led to improved patient flow, reduced length of stay, and increased patient satisfaction.
- Participating in the Connecticut Behavioral Health Partnership, which is organized through Value Options.
- Evaluating ways to implement the Community Care Team program based at Middlesex Hospital.

Obesity and Chronic Diseases Initiatives

- Collaborating with Brass City Harvest to offer a farmer's market every Friday during the summer months for local residents.
- Participating in the American Heart Association Mission Lifeline Program.
- Evaluating ways to improve meal choices at the Hospital. The Hospital began offering the Mindful Meal program, which includes healthy low-fat and low calorie options, to patients, staff and the community.
- Providing a nurse educator to patients to coordinate post-acute services and provide patient and family education. The Hospital is one of eleven hospitals in the country to participate in the American College of Cardiology Patient Navigator Program.

Tobacco Use Initiatives

- Working with the Harold Leever Regional Cancer Center to enhance smoking cessation programs.
- Evaluating opportunities to pilot an incentive program to increase smoking cessation rates.

The New SM Hospital and Tenet will provide financial support to continue implementing these initiatives. The New SM Hospital will work with GWHIP to conduct a follow-up

CHNA in 2015 and a new Implementation Strategy will be developed following the next CHNA.

25. Provide a description of plans that the New SM Hospital 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: 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.

Although the Hospital's costs are competitive (*See* Exhibit V), the New SM Hospital will continuously seek opportunities to reduce costs and improve efficiency. The specific anticipated savings are presented by expense category in response to Question 34 and described in response to Question 35.

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 is aggressively positioning its health systems to be high value, comprehensive health delivery systems that can provide care to at least a third of the regional population. Tenet is positioning each of its health systems to offer alternatives for patients to receive care at the right time in the right setting. We believe that we must establish these types of systems if we are to remain competitive in each of our markets. To this end, we are engaging rapidly on the following initiatives:

- Enhanced physician alignment;
- Population health management infrastructure and capabilities;
- Ambulatory Care Services Development;
- Post-acute care development; and
- Primary care development.

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

26. Provide a description of the New SM Hospital's plans to continue to provide services to the uninsured and underinsured. In responding to this question, please describe any changes to the Hospital's 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 the New SM Hospital 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 the New SM Hospital will provide in the area that are tailored towards the uninsured or underinsured.

The New SM Hospital will continue to provide exceptional care and the same level of services as it currently provides to the uninsured and underinsured. The New SM Hospital will adopt the existing policies at the Hospital, which will continue to help the uninsured and will offer the same level of charity care as currently provided. There are currently no plans for the New SM Hospital to work with other providers in the community regarding federally qualified health centers or low cost programs that are tailored towards the uninsured or underinsured. However, the New SM Hospital will continue to operate as a low cost hospital and provide great value to those in need.

27. 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.

Saint Mary's

Saint Mary's Administrative and Clinical Department Heads include the following. Curriculum Vitae for each are included as Exhibit W.

Chad Wable, President and Chief Executive Officer
Joe Connolly, Vice President of Community Affairs and Chief Marketing Officer
Ralph Becker, Vice President and Chief Financial Officer
Michael Novak, Vice President of Operations and Chief Information Officer
James Tucker, Vice President of Quality and Chief Nursing Officer
Clark Kearney, Vice President of Human Resources
Charles Flinn, Chief Operating Officer
Steven Schneider, MD, President of Franklin Medical Group and Chief Medical Officer

Tenet

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

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

28. 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.**

The Asset Purchase will improve the quality of health care delivery in the region because the Hospital will be part of Tenet which currently includes 80 hospitals. Tenet hospitals share best practices in a variety of areas such as service line planning, clinical operations, physician outreach, care coordination, discharge planning, and emergency preparedness. The New SM Hospital will learn from peer hospitals and improve quality by implementing best practices in the region.

The New SM Hospital would benefit from best practices and Tenet's evidence-based approach to clinical quality. The New SM Hospital physicians and clinical staff would have an opportunity to participate in Tenet's Clinical Councils, which are representative groups of physicians, nurses, and other clinical staff in specific disciplines. The Clinical Councils are designed to provide insight, perspectives and expertise that shape practice to make care more consistent with the best available evidence and clinical standards. The Clinical Councils also serve as a consistent and readily available avenue for Tenet leaders to access clinical insights.

The Asset Purchase will also improve cost effectiveness of health care delivery in the region because the New SM Hospital will have reduced supply costs through Tenet's national vendor contracts.

Medicaid recipients and indigent persons will have the same access to high quality services that they currently have. There will be no change in access to services for Medicaid recipients and indigent persons as a result of the Asset Purchase. Please see the response to Question 26 for information on charity care and financial assistance for indigent persons.

In addition, the Asset Purchase will result in a cash infusion to the Foundation . At Closing, the estimated net proceeds to the Foundation from the sale are $96 million. Please see the response to Question 38. The Foundation will provide funding to meet community health needs. Given the high level of poverty in Waterbury, the Foundation's Board will likely direct many funds to benefit indigent persons. Therefore, quality, accessibility and cost effectiveness of health care delivery in the region will improve as a result of the Asset Purchase.

29. Explain the roles that the two entities described in the July 9, 2014 Determination Letter, VHS Saint Mary's Health System, LLC and VHS of Connecticut, LLC, will play in the ownership and operation of the New SM Hospital.

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 and activities within the State of Connecticut. VHS Saint Mary's Health System, LLC has not yet been formed, but it is anticipated that it will own and operate the New SM Hospital.

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 the entity that will own and operate the New SM Hospital, 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.

Saint Mary's organizational charts prior to, and after, the proposed Asset Purchase are included at the end of the response to this question.

POST-ASSET ENTITIES

The following is a description of the post-Asset Purchase entities that will own and operate the New SM Hospital:

Tenet Healthcare Corporation (previously defined as "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 holds 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.

Figure 3 below is Saint Mary's organizational chart prior to the Asset Purchase:

Figure 3: Saint Mary's Current Organization

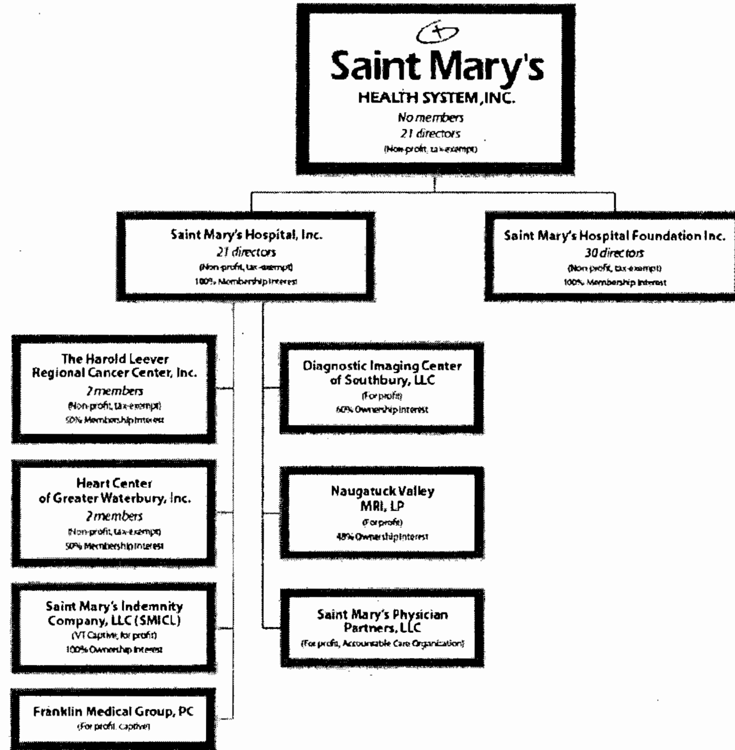
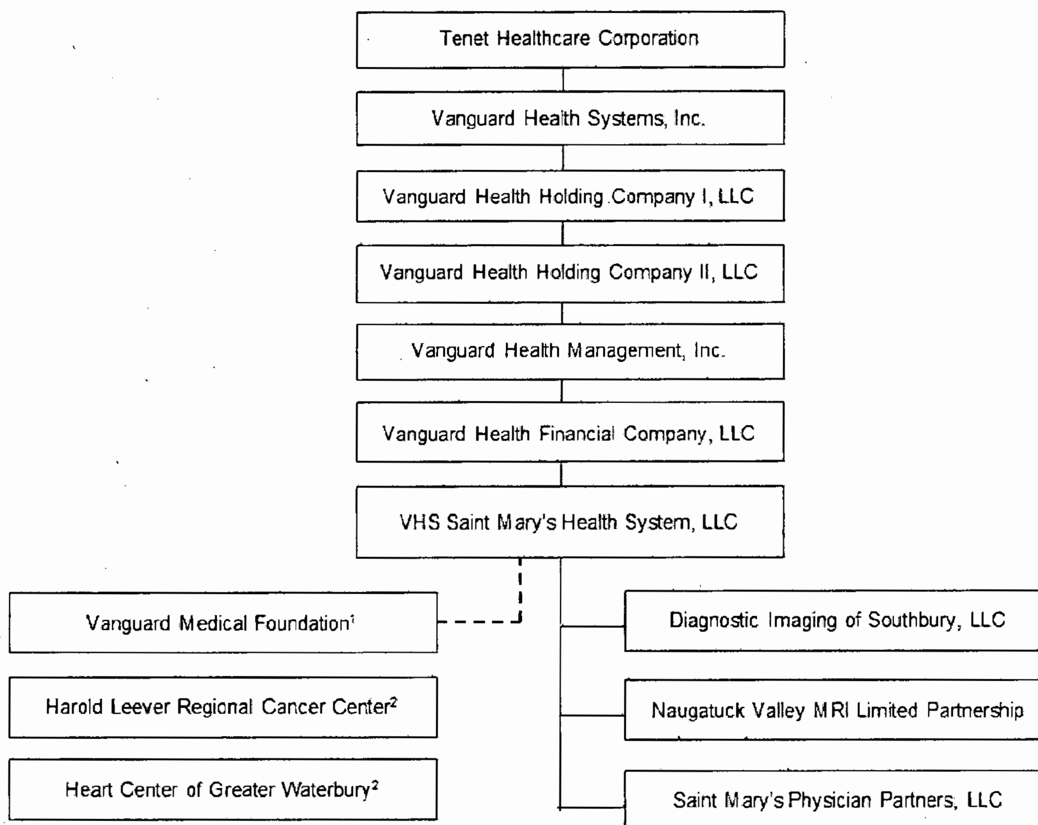


Figure 4 below is Saint Mary's organizational chart after the Asset Purchase:

Figure 4: Saint Mary's Proposed Organization Post Closing



[1]The medical foundation will acquire the assets and assume the liabilities of Franklin Medical Group, P.C.
[2]These are 501(c)(3) organizations that will be reorganized post-closing.

31. Please provide the date on which the Hospital filed audited financial statements with OHCA. SMHS may reference these statements in responding to questions.

Saint Mary's filed audited financial statements with OHCA on February 26, 2014.

30-1. List all funding or financing sources for the $150,000,000 Asset Purchase by Tenet and Tenet's $85,000,000 capital expenditure commitment, and the dollar amount of each source. 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.

Tenet will use cash to purchase Saint Mary's assets for $150,000,000. Cash will also be used for the $85,000,000 in capital expenditures. Details such as interest rate, term, and monthly payment amounts do not apply to this Asset Purchase.

31.-1 Describe in detail how this proposal will affect the financial strength of the state's health care system or will be financially feasible.

In order to sustain the excellent quality of care that the Hospital provides in the Waterbury community, and also adapt to the new mandates of the PPACA, the Hospital needs to move from being a stand-alone hospital, and join with a national 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 patient's 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 same care provided in a hospital emergency room. This results in a reduction in the cost of health care.

To transition effectively from a volume based system to one based on value, the Hospital would not have adequate resources for the appropriate investment in information systems. As a part of a larger system, the New SM Hospital will benefit from advanced information systems that allow clinical integration and coordination of care.

In order to accomplish the goals of treating more patients with quality, accessible care, we know the following steps need to be taken:

- Align hospitals' physicians and other providers across the continuum of care so that they work together, and know the patient's medical history before treatment;
- Utilize evidence-based practices to improve quality of care and patient safety;
- Improve efficiency through productivity and financial management; and
- Develop integrated information systems.

In order to accomplish these goals, a hospital and its affiliated health care system need capital (and/or access to capital at reasonable rates) in order to invest in the future. Physical plant renovations are constantly required just to keep hospitals in good working order. For many hospitals like Saint Mary's, which was built in 1907, this task is enormous and drains capital that could be used for investing in the future. In 2014, we are at a threshold of moving into

the future where health care can be better than before and, at the same time, be accessible to more people. But this will not happen without a large infusion of cash, and a great deal of expertise and experience in learning how to make the necessary changes. Tenet offers both financial strength and health care experience. Tenet will bring the strength of their national system to Waterbury and provide innovation that one hospital alone could not possibly afford to do independently.

Connecticut's hospitals and their affiliated hospital networks are an important part of the State's health care system. If hospitals lose money, they cannot offer some of the newer services, including new models of preventive health, and a less-costly way of providing health care. This puts stress on other State health care programs, and costs the State additional money. If a hospital system is financially strong, it stands to reason that it will provide additional strength to the State's health care system rather than putting more demands on State resources.

The Hospital is facing a $10 million reduction in funding next year. The Hospital has already experienced government cutbacks in reimbursement of over $8 million in the last 3 years and it is facing a loss of over $5 million in State funding in FY2015. It also has a pension fund that needs capital and debt that needs to be reduced. With costs going up, and reimbursement going down, remaining a stand-alone hospital will result in a further drain on its financial resources.

The Hospital has been financially sound in its operations over the last half-decade. However, this is not enough during a time when in order to remain financially sound, it requires a significant investment of capital to keep the infrastructure of the system properly maintained for present and future use and improve the accessibility and efficiency of the way in which health care is provided. Tenet is prepared to make that investment, and has the financial resources to pay for this investment without borrowing. The Tenet proposal is financially feasible, and will add to the strength of the State's health care system.

32. Please provide the current payer mix for the Hospital and projected payer mix for New SM Hospital (based on the number of patients, not based on revenue) in the following reporting format:

Table 8: Patient Population/Payer Mix

Total Facility	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	44.1%	44.1%	44.1%	44.1%
Medicaid* (includes other medical assistance)	28.6%	28.6%	28.6%	28.6%
CHAMPUS or TriCare	0.3%	0.3%	0.3%	0.3%
Total Government Payers	73.0%	73.0%	73.0%	73.0%
Commercial Insurers*	22.5%	22.5%	22.5%	22.5%
Uninsured	3.3%	3.3%	3.3%	3.3%
Workers Compensation	1.3%	1.3%	1.3%	1.3%
Total Non-Government Payers	27.0%	27.0%	27.0%	27.0%
Total Payer Mix	100.00%	100.00%	100.00%	100.00%

*Includes managed care activity.

33. Provide the assumptions used to project the patient population mix after the proposed Asset Purchase.

The current payer mix is based on Fiscal Year 2014 year-to-date (October 1, 2013 through April 30, 2014). The patient population mix is not expected to change as a result of the Asset Purchase. Therefore, the projections assume the same payer mix for the first three years following the Asset Purchase.

34. 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 I(A) -- SMHS without the CON project (Note that the actual results for the fiscal year reported in the first column must agree with SMHS' audited financial statements.); and**
b. **Financial Attachment I(B) -- The New SM Hospital with the CON project and incremental to the CON project.**

The projections must include the first three full fiscal years of the project.

Financial Attachment I(A) and the assumptions used for it are attached as Exhibit Y and Financial Attachment I(B) and the assumptions used for it are attached as Exhibit Z. Please note the projections are presented in ($thousands).

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

The assumptions utilized for developing Financial Attachment I are included as part of Exhibit Y and Exhibit Z.

36. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of the New SM Hospital.

There are no projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of the New SM Hospital.

37. 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 the New SM Hospital will willingly negotiate with the payers that the Hospital currently has contracts with?

The New SM Hospital 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.

38. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of SMHS and/or the Hospital's debt and pension obligations.

The Asset Purchase will satisfy the Hospital's debt and fully fund the pension obligations for church plans. Tenet has committed to fully funding the pension plan and ensuring security with the pensioners. Tenet will deduct the underfunded status of the plan at the time of the Closing from the $150 million purchase price, which is approximately $52 million. The proceeds will also be used to satisfy the $21.5 million CHEFA bonds the Hospital has outstanding. The Hospital will utilize the debt service reserve investments of $6.2 million and part of the remaining proceeds to satisfy the bonds. Please see Table 1 on for details on the satisfaction of the debt and the remaining cash to be contributed to the Foundation.

39. Please explain in detail Tenet's commitment to spend no less than $85 million over seven years on capital expenditures and service improvements. Also, please specify the following:

The $85 million has been committed to the Waterbury community but has not been specifically designated as to what portion would be allocated to the New SM Hospital or what portion of that would be allocated to each of the seven years. Tenet expects to seek the input of the New SM Hospital's Advisory Board and medical staff in making those determinations.

a. The annual amounts projected to be available to the New SM Hospital for each of the seven years;

Annual amounts have not been specified by year. 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 seven years.

b. The capital projects that are deemed top priorities by the Applicants; and

Tenet expects to seek the input of the New SM Hospital's Advisory Board to prioritize capital projects based on hospital and community needs.

c. **The service improvements that are deemed top priorities by the Applicants.**

Tenet expects to seek the input of the New SM Hospital's Advisory Board to prioritize service improvements based on hospital and community needs.

40. 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[5] 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).**

Table 9: Current Staffing Levels

	Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nursing Hours per Patient Day
Name of Hospital Unit or Department	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	
Critical Care	1:1.7	1:1.7	1:1.7	1:2	1:2	1:2	16.31
Telemetry	1:2.4	1:2.6	1:3.4	1:3.4	1:3.4	1:4.25	9.41
Cardiovascular Unit	1:2	1:2	1:2	1:2	1:2	1:2	14.68
Women & Infant's Center (mother/baby couplets)	1:6	1:8	1:6	1:8	1:8	1:6	10.06
General Psych - O'Brien One	1:2.2	1:2.2	1:5.5	1:5.5	1:5.5	1:5.5	5.98
Ortho Neuro - O'Brien Four	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5	7.92
General Surgery - O'Brien Seven	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5	8.06
Medical Acute - Sacred Heart Five	1:2.9	1:3.2	1:3.2	1:4.2	1:4.2	1:4.7	8.09
Oncology - Xavier Three	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:7	7.58
Emergency Department	1:1.2	1:1.2	1:1.3	1:4	1:4	1:5	1.49
Neonatal Intensive Care Unit	1:2	1:2	1:2	1:2	1:2	1:2	18.18

[5] Nursing staff consists of registered nurses (RNs), licensed practical nurses (LPNs) and nurses' aides (NAs) providing direct patient care

b. **Provide the projected levels of staffing by department and/or unit for the New SM Hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:**[6]
   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.**

Table 10: Projected Staffing Levels FY 2015

	Average Nurse to Patient Ratio			**Average RN to Patient Ratio**		
Name of Hospital Unit or Department	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**	**Shift #1 AM**	**Shift #2 PM**	**Shift #3 overnight**
Critical Care	1:1.7	1:1.7	1:1.7	1:2	1:2	1:2
Telemetry	1:2.4	1:2.6	1:3.4	1:3.4	1:3.4	1:4.25
Cardiovascular Unit	1:2	1:2	1:2	1:2	1:2	1:2
Women & Infant's Center (mother/baby couplets)	1:6	1:8	1:6	1:8	1:8	1:5.5
General Psych - O'Brien One	1:2.2	1:2.2	1:5.5	1:5.5	1:5.5	1:5.5
Ortho Neuro - O'Brien Four	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5
General Surgery - O'Brien Seven	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5
Medical Acute - Sacred Heart Five	1:2.9	1:3.2	1:3.2	1:4.2	1:4.2	1:4.7
Oncology - Xavier Three	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:7
Emergency Department	1:4	1:4	1:5	1:4	1:4	1:5
Neonatal Intensive Care Unit	1:2	1:2	1:2	1:2	1:2	1:2

[6] Staffing ratios are subject to unit configuration and size, technology, acuity and the experience level of the staff.

Table 11: Projected Staffing Levels FY 2016[7]

Name of Hospital Unit or Department	Average Nurse 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
Critical Care	1:1.7	1:1.7	1:1.7	1:2	1:2	1:2
Telemetry	1:2.4	1:2.6	1:3.4	1:3.4	1:3.4	1:4.25
Cardiovascular Unit	1:2	1:2	1:2	1:2	1:2	1:2
Women & Infant's Center (mother/baby couplets)	1:6	1:8	1:6	1:8	1:8	1:6
General Psych - O'Brien One	1:2.2	1:2.2	1:5.5	1:5.5	1:5.5	1:5.5
Ortho Neuro - O'Brien Four	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5
General Surgery - O'Brien Seven	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5
Medical Acute - Sacred Heart Five	1:2.9	1:3.2	1:3.2	1:4.2	1:4.2	1:4.7
Oncology - Xavier Three	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:7
Emergency Department	1:4	1:4	1:5	1:4	1:4	1:5
Neonatal Intensive Care Unit	1:2	1:2	1:2	1:2	1:2	1:2

[7] Staffing ratios are subject to unit configuration and size, technology, acuity and the experience level of the staff.

Table 12: Projected Staffing Levels FY 2017[8]

Name of Hospital Unit or Department	Average Nurse 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
Critical Care	1:1.7	1:1.7	1:1.7	1:2	1:2	1:2
Telemetry	1:2.4	1:2.6	1:3.4	1:3.4	1:3.4	1:4.25
Cardiovascular Unit	1:2	1:2	1:2	1:2	1:2	1:2
Women & Infant's Center (mother/baby couplets)	1:6	1:8	1:6	1:8	1:8	1:6
General Psych - O'Brien One	1:2.2	1:2.2	1:5.5	1:5.5	1:5.5	1:5.5
Ortho Neuro - O'Brien Four	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5
General Surgery - O'Brien Seven	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:5.5
Medical Acute - Sacred Heart Five	1:2.9	1:3.2	1:3.2	1:4.2	1:4.2	1:4.7
Oncology - Xavier Three	1:3.1	1:3.1	1:3.6	1:4.4	1:4.4	1:7
Emergency Department	1:4	1:4	1:5	1:4	1:4	1:5
Neonatal Intensive Care Unit	1:2	1:2	1:2	1:2	1:2	1:2

[8] Staffing ratios are subject to unit configuration and size, technology, acuity and the experience level of the staff.

41. 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.

There is no expected change in the nurse to patient ratios between Fiscal Year 2013 and Fiscal Year 2014. In addition, there is no expected change projected for the three Fiscal Years following the Asset Purchase.

42. For FY 2013, 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") 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.**

The chart below includes the Ancillary Caregivers that are assigned to a hospital unit to provide direct patient care. The chart includes the hospital unit, type of ancillary caregiver and the average hours per week dedicated to patient care.

Table 13: Ancillary Caregivers by Hospital Unit[9]

		Current Levels	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017
Area	Type	Average Hours Per Week				
Cardiovascular Unit	APRNs	75	75	75	75	75
General Psych - O'Brien One	Occupational Therapist	36	36	36	36	36
	Social Worker	36	36	36	36	36
Women & Infant's Center	Surgical Technologist	4	4	4	4	4
	Lactation Specialist	20	20	20	20	20
	Massage Therapist	20	20	20	20	20

[9] Staffing ratios are subject to unit configuration and size, technology, acuity and the experience level of the staff.

43. 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 42 above provided patient care in FY 2013 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

There is no expected change in the use of the Ancillary Caregivers described in Question 42 between Fiscal Year 2014 and the three full Fiscal Years following the Asset Purchase.

44. Provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for 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. Cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

The Hospital, as directed in the Connecticut General Statues (Sec. 19a-89e), has developed staffing plans for each of the inpatient units, critical care areas, and the Emergency Department. The certification document is included as Exhibit AA.

45. Please provide copies of all CMS statements of deficiencies and plans of correction (CMS Form 2567) for hospitals owned by Tenet for the three (3) 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.

It would be extremely cumbersome and time-consuming to obtain these documents as they are kept in hard-copy form at each individual hospital, and there are no aggregate compilations at the corporate level. Furthermore, 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. 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 their robust quality program (the "Tenet Quality Program") instituted at all of their 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
2. 26 facilities recognized as TJC top performers on key quality measures
3. TJC Disease-Specific Certification —81 Disease-Specific Certification designations
4. 5 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.

46. Provide a copy of any of the following policies and procedures that will be in place at the New SM Hospital if the Asset Purchase is approved:

a. New SM Hospital Collection Policies (including charity care and bad debt)

The New SM Hospital will adopt the Hospital's current charity care policy. Attached as Exhibit BB is Saint Mary's current charity care policy.

b. The annual or periodic review and/or revision to the New SM Hospital's pricing structure (the chargemaster or pricemaster).

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. The annual or periodic market rate assessment for the New SM Hospital.

Not applicable.

47. The Hospital has provided OHCA with its annual FY 2014 pricemaster, which was most recently updated for the month of June, 2014. With respect to this submission, please answer the following:

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

No. The pricemaster will not change as a result of the Asset Purchase, but New SM Hospital will conduct periodic reviews of the pricemaster, as it currently does.

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

Not applicable.

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.

Not applicable.

48. Please provide monthly financial statistics report for FY 2014, current month and year-to-date, and comparable period for FY 2013 to OHCA, for both the Hospital only and for SMHS, with the Application and thereafter on a monthly basis for each month, until a public hearing in this matter is held. The following financial measurements/indicators should be addressed in the report:

Table 14: Monthly Financial Statistics for May 2014, May 2014 Year-To-Date and a Comparison of the Previous Year

Monthly Financial Measurement/Indicators ($ in thousands)	Saint Mary's Hospital, Inc. May 2014	Saint Mary's Hospital, Inc. Prior Year	Saint Mary's Hospital, Inc. YTD May 2014	Saint Mary's Hospital, Inc. Prior year	Saint Mary's Health System, Inc. May 2014	Saint Mary's Health System, Inc. Prior Year	Saint Mary's Health System, Inc. YTD May 2014	Saint Mary's Health System, Inc. Prior year
A. Operating Performance								
Operating Margin	5.4%	4.1%	4.0%	4.6%	5.4%	4.1%	4.0%	4.6%
Non-Operating Margin	0.9%	1.2%	0.3%	0.6%	0.9%	1.2%	0.3%	0.6%
Total Margin	6.4%	5.2%	8.2%	8.9%	6.4%	5.2%	8.2%	8.9%
Bad Debt as % of Gross Revenue	1.1%	1.7%	1.6%	1.8%	1.1%	1.7%	1.6%	1.8%
B. Liquidity								
Current Ratio	2.2	2.0	2.2	2.0	2.2	2.0	2.2	2.0
Days Cash on Hand	67	71	67	72	67	71	67	72
Days in Net Accounts Receivable	41	39	38	39	41	39	38	39
Average Payment Period	46	61	50	65	46	61	50	65
C. Leverage and Capital Structure								
Long-term Debt to Equity	0.33	0.56	0.33	0.56	0.33	0.53	0.33	0.53
Long-term Debt to Capitalization	0.25	0.36	0.25	0.36	0.25	0.35	0.25	0.35
Unrestricted Cash to Debt	2.1	1.9	2.1	1.9	2.1	1.9	2.1	1.9
Times Interest Earned Ratio	11.9	7.8	8.5	8.4	11.9	7.8	8.5	8.4
Debt Service Coverage Ratio	7.45	7.82	7.45	7.82	7.45	7.82	7.45	7.82
Equity Financing Ratio	3.3	4.7	3.3	4.7	3.3	4.7	3.3	4.7
D. Additional Statistics								
Income from Operations	$ 1,310	$ 915	$ 7,326	$ 7,998	$ 1,307	$ 912	$ 7,302	$ 7,974
Revenue Over/(Under) Expense	$ 1,531	$ 1,174	$ 7,950	$ 8,978	$ 1,528	$ 1,171	$ 7,926	$ 8,954
EBITDA	$ 2,282	$ 1,857	$ 15,147	$ 15,576	$ 2,285	$ 1,860	$ 15,171	$ 15,600
Patient Cash Collected	$ 22,327	$ 21,807	$ 171,447	$ 172,554	$ 22,327	$ 21,807	$ 171,447	$ 172,554
Cash and Cash Equivalents	$ 46,968	$ 47,363	$ 46,968	$ 47,363	$ 46,969	$ 47,364	$ 46,969	$ 47,364
Net Working Capital	$ 31,646	$ 27,256	$ 31,646	$ 27,256	$ 31,874	$ 27,484	$ 31,874	$ 27,484
Unrestricted Assets	$ 48,185	$ 26,105	$ 48,185	$ 26,105	$ 49,935	$ 27,855	$ 49,935	$ 27,855
Credit Ratings (Moody's)	Ba2	Ba2	Ba2	Ba2	Ba2	Ba2	Ba2	Ba2

49. Please describe in detail the corporate structure, governance, controlling body, purpose and function of the Saint Mary's Hospital Foundation, Inc. ("Foundation") after the Asset Purchase, including the identity of all members of the Foundation and their authority.

Please see response to Question 9.

50. Provide a copy of the SMHS's and 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 the proposed New SM Hospital 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 New SM Hospital will continue to provide in these community benefit categories.

The New SM Hospital's IRS Tax Form 990 is included as Exhibit CC. The New SM Hospital will continue to provide financial assistance and community benefits to the Waterbury area. As noted in response to Question 26, the New SM Hospital is committed to providing the same, if not greater, financial assistance and community benefit to the local community. Tenet's policies will be compared to the Hospital's policies, and the New SM Hospital will utilize the polices that give greater financial assistance to the uninsured and underinsured. See Table 15 below for 3 year projections.

Table 15: Schedule H, Part 1, Section 7 (Financial Assistance) from IRS Form 990

Schedule H, Part I, Section 7 - Financial Assisstance				
		Projected		
		2015	2016	2017
a	Financial Assistance at cost	1,300,000	1,313,000	1,326,130
b	Medicaid	16,836,422	17,004,786	17,174,834
c	Cost of other means-tested government programs	-	-	-
d	Total Financial Assistance	18,136,422	18,317,786	18,500,964
	Other Benefits			
e	Community health improvement services and community benefit operations	280,042	282,842	285,671
f	Health professions education	2,561,128	2,586,739	2,612,606
g	Subsidized health services	3,238,553	3,270,938	3,303,648
h	Research	111,980	113,100	114,231
i	Cash and in-kind contributions for community benefit	79,290	80,083	80,884
j	Total Other Benefits	6,270,992	6,333,702	6,397,039
k	Total	24,407,414	24,651,488	24,898,003

51. 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 the proposed New SM Hospital 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 New SM Hospital will continue to provide in these community building activity categories.

The New SM Hospital will continue to provide financial support for community building activities in the Waterbury area. As noted in Question 26, Tenet is committed to providing the same, if not greater, financial support and community benefit to the local community. Tenet's policies will be compared to the Hospital's policies, and the New SM Hospital will utilize the polices that give greater financial support related to community building activities. See Table 16 below for 3 year projections.

Table 16: Schedule H, Part II (Community Building Activities) from IRS Form 990

Schedule H, Part II - Community Building Activities				
		Projected		
		2015	2016	2017
1	Physical improvements and housing	204	206	208
2	Economic development			
3	Community support			
4	Environmental improvements			
5	Leadership development and training for community members			
6	Coalition building			
7	Community health improvement advocacy			
8	Workforce development	160,186	161,788	163,406
9	Other			
10	Total	160,390	161,994	163,614

52. Please discuss whether the Asset Purchase and formation of the New SM Hospital 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.

As noted in Applicants' response to Question 22, common ownership of the hospitals in Waterbury will allow for a coordinated approach to care. By coordinating care among the hospitals in Waterbury and community physicians, 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, both Waterbury hospitals will be able to take advantage of Tenet's greater economies of scale and superior supply chain management, which will further reduce the hospitals' 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 the Waterbury hospitals 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 the Waterbury hospitals to offer plans in which the hospitals assume financial risk which, with the support of Tenet, the hospitals will be in an improved position to assume.

Tenet expects that for all of the reasons noted above and in response to Question 22, the transaction will benefit consumers from a financial standpoint, as both hospitals will have a lower cost structure and superior, cost-competitive products than they otherwise would be in a position to offer.

53. Provide details of plans to be put in place to ensure the proposed health care services provided by the New SM Hospital 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/templates/browse.aspx?lvl=2&lvlID=15#sthash.U320zUXq.dpuf)

The Hospital has several programs in place to adhere to the National Standards on Culturally and Linguistically Appropriate Services. The Hospital has contracted with FSW (formerly Family Services Woodfield) to provide face to face sign language interpreters for the hearing impaired. Video conferencing is also available for sign language interpretation.

The Hospital also contracts with Language Line Services, which provides translation for non-English speaking patients. Two handset phones are strategically placed within the Hospital. The patient has one handset while the provider has the other handset. The Language Line

Services' interpreter participates in the patient visit by providing translation over the telephone.

The Hospital also participates in the Connecticut Hospital Association Diversity Collaborative (the "Collaborative"). As part of the Collaborative, the Hospital hosts an educational fair during Cultural Diversity Week. At this fair, brochures on CLAS standards are distributed.

In addition, the Hospital's Education Department has incorporated Cultural Diversity Training in the annual e-learning program, which is mandatory for all employees. Cultural Diversity Training is also part of new employee orientation.

Finally, The Hospital's Education Department and Nursing Administration Department are evaluating other training programs to increase adherence to CLAS. The Hospital will support these existing programs that increase adherence to CLAS standards.

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LIST OF EXHIBITS

	Description
A.	Asset Purchase Agreement By and Among Saint Mary's Health System, Inc., VHS of Connecticut, LLC, VHS Saint Mary's Health System, LLC and Tenet Healthcare Corporation
B.	Community Health Needs Assessment Final Summary Report published by the Greater Waterbury Health Improvement Partnership dated September 2013.
C.	Saint Mary's Health System, Inc. & Saint Mary's Hospital, Inc. Board of Directors Meeting Minutes dated June 30, 2014 & July 3, 2014
D.	Affiliation Timeline
E.	Profile of Tenet Healthcare Corporation Tenet's Catholic Hospital Experience
F.	High Level Comparison of Offers Between Tenet and Party 2 Guiding Principles of Affiliation
G.	Comparison of Offers Between Tenet and Party 2
H.	Reserved
I.	Saint Mary's Disclosure/Conflict of Interest Forms
J.	Tenet's Disclosure/Conflict of Interest Forms
K.	Request for Proposal Response from Principle Valuation, LLC
L.	Fairness Opinion by Principle Valuation, LLC
M.	Select Pages from Tenet's 2013 10-K
N.	Tenet's 2014 2nd Quarter 10-Q
O.	Saint Mary's Foundation Binders – one copy bulk filed with AG and OHCA
P.	Correspondence with Two Additional Parties related to Transfer of Saint Mary's Ownership
Q.	Public Hearing Transcript dated July 28, 2014
R.	Reduction in Medicare Reimbursement Over Next 8 Years
S.	List of Outpatient Services by Location

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T.	Implementation Strategy for the Community Needs Assessment
U.	Saint Mary's Health System, Inc.'s and Saint Mary's Hospital, Inc.'s Board of Directors Meeting Minutes dated September 12, 2013
V.	Saint Mary's Costs Compared to Other Markets
W.	Saint Mary's Curriculum Vitae Chad Wable, President & CEO Joseph Connolly, VP of Community Affairs and Chief Marketing Officer Ralph W. Becker, VP of Finance and Chief Financial Officer Michael Novak, VP of Operations and Chief Information Officer James Tucker, VP of Quality and Chief Nursing Officer Clark Kearney, VP of Human Resources Charles Flinn, Chief Operating Officer Steven Schneider, M.D., President of Franklin Medical Group and Chief Medical Officer
X.	Tenet's Curriculum Vitae Kelvin A. Baggett, M.D., Chief Medical Officer Mark R. Montoney, M.D., Chief Medical Officer Harold (Trip) Pilgrim, Senior Vice President, Development Eric G. Wexler, Chief Executive Officer, Northeast Market
Y.	Financial Attachment I (A) Saint Mary's Health System, Inc. Without CON
Z.	Financial Attachment I(A) New SM Hospital With CON
AA.	Certification Document for Nursing Staffing Plans
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A

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ASSET PURCHASE AGREEMENT

BY AND AMONG

SAINT MARY'S HEALTH SYSTEM, INC.,

SAINT MARY'S HOSPITAL, INC.,

VHS OF CONNECTICUT, LLC,

VHS SAINT MARY'S HEALTH SYSTEM, LLC

AND

TENET HEALTHCARE CORPORATION

__________________, 2014

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EXHIBITS

Description	***Exhibit***

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Assignment and Assumption Agreement (Real Property Leases)....................2
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SCHEDULES

Description	***Schedule***

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ASSET PURCHASE AGREEMENT

This **ASSET PURCHASE AGREEMENT** (the "Agreement") is made and entered into as of the ________ day of ___________, 2014, by and among Saint Mary's Health System, Inc., a Connecticut not-for-profit corporation ("Saint Mary's Health"), Saint Mary's Hospital, Inc. ("SMH, Inc."; together with Saint Mary's Health, each a "Seller" and collectively, "Sellers"), VHS Saint Mary's Health System, LLC, a Delaware limited liability company ("Buyer"), VHS of Connecticut, LLC, a Delaware limited liability company ("Parent"), and Tenet Healthcare Corporation, a Nevada corporation ("Tenet"), joining for the limited purposes described herein.

RECITALS:

WHEREAS, Sellers own and operate the Facilities (as hereinafter defined), including, but not limited to, a 347-bed general acute care hospital located in Waterbury, Connecticut (the "Hospital").

WHEREAS, Sellers desire to sell to Buyer, and Buyer desires to purchase from Sellers, substantially all of the assets, rights and properties of Sellers relating to the Facilities as described herein, on the terms and conditions set forth in this Agreement.

WHEREAS, Buyer is willing to assume the Assumed Liabilities from Sellers as described herein, on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the Recitals and of the mutual covenants, conditions, and agreements set forth herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is hereby agreed as follows:

ARTICLE I
DEFINITIONS

When used in this Agreement, the following terms shall have the meanings specified, which meanings shall be equally applicable to both the singular and plural forms of such terms.

1.1 "Accounts Receivable" shall mean all accounts, notes, interest, and other receivables of Sellers relating to the Facilities, including those certain accounts, notes, or other amounts receivable from physicians listed in Schedule 1.1, and all claims, rights, interests, and proceeds related thereto, including all accounts and other receivables, disproportionate share payments, and all rights to receive funds relating to upper payment limits, arising from the rendering of services to inpatients and outpatients at the Facilities, billed and unbilled, recorded and unrecorded, for services provided by the Sellers prior to the Closing whether payable by private pay patients, private insurance, third party payors, Government Payment Programs, or by any other source.

1.2 "Advances" shall mean all of those advance payments, prepayments, prepaid expenses, deposits, and the like that exist as of the Closing Date, subject to the prorations provided in Section 2.5 of this Agreement, that were made with respect to the

operation of the Facilities, the current categories and amounts of which are set forth on Schedule 1.2.

1.3 "Affiliate" shall mean, when used with respect to a particular Person any Person who, directly or indirectly, controls, is controlled by, or is under common control with that 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; *provided* however that no Partial Subsidiary for which Sellers own less than a majority of its equity or other ownership interests shall be considered an Affiliate of Sellers.

1.4 "Affiliated Group" shall mean 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.

1.5 "Agreement" shall mean this Asset Purchase Agreement, together with the Exhibits and the Schedules attached hereto.

1.6 "Assignment and Assumption Agreement" shall mean the Assignment and Assumption Agreement in substantially the form of Exhibit 1.

1.7 "Assignment and Assumption of Leases" shall mean the Assignment and Assumption Agreement (Real Property Leases) in substantially the form of Exhibit 2.

1.8 "Assumed Contracts" shall mean all of Sellers' rights, to the extent assignable or transferable, to the Contracts listed on Schedule 1.8 and all Immaterial Contracts other than the Excluded Contracts.

1.9 "Assumed Liabilities" shall mean the following liabilities of the Sellers :

(a) those liabilities and obligations arising after the Effective Time pursuant to the Assumed Contracts, Assumed Real Property Leases and Assumed Personal Property Leases;

(b) Sellers' obligations arising after the Effective Time with respect to any Assumed Permits, but excluding any liabilities or obligations under such Assumed Permits for acts or omissions occurring or conditions existing prior to the Effective Time;

(c) the trade accounts payable and current liabilities of the Facilities as of the Effective Time, but only to the extent such accounts payable and current liabilities are included in the calculation of the Final Net Working Capital Amount;

(d) obligations and liabilities as of the Effective Time with respect to (i) vacation time, (ii) sick time, (iii) any other paid time off, and (iv) unused health reimbursement account balances of Sellers' employees who accept employment with Buyer or Buyer's Affiliate as of the Effective Time, and related taxes, but only to the extent obligations and liabilities for vacation time, sick time and any other paid time off are included in the calculation of the Final Net Working Capital Amount and only to the extent that such

reimbursement account balances are actually transferred to the applicable benefit plan of Buyer or Buyer's Affiliate from Sellers' applicable benefit plan;

(e) liabilities or obligations with respect to Taxes relating to the Facilities and the Purchased Assets with respect to periods commencing on or after the Effective Time;

(f) all Taxes allocable to Buyer pursuant to Section 2.5, Section 11.7, and Section 13.10 hereof;

(g) all outstanding liabilities under the Pension Plan for Employees of St. Mary's Hospital Corporation and Sellers' retiree medical plan (the "Retiree Medical Plan"); and

(h) any other liabilities specifically identified in Schedule 1.9.

1.10 "Assumed Permits" shall mean all of Sellers' rights, to the extent assignable or transferable, to the Permits.

1.11 "Assumed Personal Property Leases" shall mean all of the Sellers' interest, to the extent assignable or transferable, in and to all personal property leases with respect to the operation of the Facilities listed in Schedule 1.11.

1.12 "Assumed Real Property Leases" shall mean all of the Sellers' interest, to the extent assignable or transferable, in and to all real property leases with respect to the operation of the Facilities listed in Schedule 1.12.

1.13 "Bill of Sale" shall mean a Bill of Sale in substantially the form of Exhibit 3.

1.14 "Business Day" shall mean any day other than the days on which banks in Waterbury, Connecticut are required or authorized to close.

1.15 "Buyer's Indemnified Persons" shall mean Buyer, Parent and Tenet and their respective Affiliates, officers, directors, members, managers, employees, agents and representatives.

1.16 "Closing" has the meaning set forth in Section 3.1.

1.17 "Closing Date" shall mean ____________, or such other date agreed by Buyer and Sellers at which the Closing occurs.

1.18 "Code" shall mean the Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

1.19 "Contracts" shall mean all of Sellers' commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Purchased Assets or the

operation of the Facilities to which Sellers or any Affiliate of Sellers is a party or by which they or any of the Purchased Assets are bound.

1.20 "Cost Reports" shall mean all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them.

1.21 "Effect" shall mean any state of facts, change, development, event, occurrence, effect or condition.

1.22 "Effective Time" shall mean 12:01 a.m., Eastern Standard Time, on the day following the Closing Date, subject to the occurrence of the Closing.

1.23 "EFT Account" shall mean the electronic funds transfer account of the Facilities and all information necessary to access such account.

1.24 "ERISA" has the meaning set forth in Section 4.14.

1.25 "Estimated Net Working Capital Amount" has the meaning set forth in Section 2.7.

1.26 "Excluded Assets" shall mean all the assets and properties of the Sellers described below:

(a) cash, cash equivalents, marketable securities and short-term investments, including, without limitation, cash in the EFT Account immediately prior to the Effective Time;

(b) 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), trusts related to employee benefits, trusts related to self-insurance, donor-restricted assets, beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(c) all intercompany receivables of Sellers with any of their Affiliates;

(d) any current assets of Sellers that are not included in the Final Net Working Capital Amount;

(e) all rights to refunds, credits, deposits, prepayments, or the equivalent owing to Sellers from any taxing authority resulting from periods prior to the Effective Time, and the right to pursue appeals of same;

(f) all claims, rights, interests, and proceeds (whether received in cash or by credit to amounts otherwise due to a third party) with respect to amounts overpaid with respect to the Facilities to any third party with respect to periods prior to the Closing Date;

(g) all bank accounts relating to the Facilities, other than the EFT Account;

(h) all writings and other items that are protected from discovery by the attorney-client privilege, the attorney work product doctrine, or any other cognizable privilege or protection of Sellers that are not related to any legal matter or Proceeding or potential Proceeding which is an Assumed Liability;

(i) any Cost Report settlements with respect to Cost Report periods ended on or prior to Closing;

(j) any assets owned and provided by vendors of goods or services to the Facilities;

(k) unclaimed property of any third party with respect to the operation of the Facilities, including, without limitation, property that is subject to applicable escheat Laws;

(l) all rights, claims, and choses in action of Sellers with respect to the operation of the Facilities with respect to periods prior to the Closing Date set forth in Schedule 1.26(l), and any payments, awards, or other proceeds resulting therefrom;

(m) all interests in, and assets related to the Foundation, including the name thereof;

(n) the Excluded Contracts;

(o) the portions of inventory, prepaid expenses and the like, and other Purchased Assets disposed of, expended, or canceled, as the case may be, by the Facilities prior to the Closing Date in the ordinary course of business;

(p) all organizational documents of Sellers and their Affiliates, unless the equity interest of such Affiliate is being transferred to Buyer at the Closing;

(q) all Permits and Records not legally transferable or assignable to Buyer or not relating to the ownership of the Purchased Assets or the operation of the Facilities;

(r) all equity interests in SMH, Inc.;

(s) all assets of the Partial Subsidiaries, including without limitation, all assets of Diagnostic Imaging of Southbury, LLC; and

(t) any other assets specifically identified in Schedule 1.26(t).

1.27 "Excluded Contracts" shall mean the Contracts listed on Schedule 1.27 and all other Contracts that are not Assumed Contracts.

1.28 "Excluded Liabilities" shall mean all liabilities of Sellers other than the Assumed Liabilities, including, without limitation, the following liabilities:

(a) those claims and obligations (if any) specified in Schedule 1.28(a);

(b) any liabilities or obligations associated with or arising out of any of the Excluded Assets, including, without limitation, the Excluded Contracts;

(c) Taxes incurred by the Sellers, the Facilities or in connection with the operation of the Facilities, with respect to periods prior to the Effective Time (*provided*, however, that this clause (c) shall not apply to any and all Taxes payable with respect to any employee benefits constituting Assumed Liabilities and any Taxes allocable to Buyer under Section 2.5 hereof);

(d) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 4.15 of the Sellers' Disclosure Schedule and claims or potential claims for medical malpractice or general liability relating to events that occurred or that allegedly occurred prior to the Effective Time;

(e) liabilities arising from any violation of Law by Sellers or their directors, officers, employees, representatives, and agents;

(f) liabilities and obligations arising out of transactions, commitments, infringements, acts or omissions (including the breach by Sellers of any Contract) by or on behalf of Sellers or its employees, agents or independent contractors occurring prior to, on or after the Closing Date;

(g) any obligation or liability asserted under the federal Hill-Burton program or other restricted grant and loan programs with respect to the ownership or operation of the Facilities or the Purchased Assets prior to the Effective Time;

(h) all liabilities and obligations relating to any oral agreements, oral contracts, or oral understandings with any referral sources including, but not limited to, physicians, made prior to the Effective Time unless reduced to writing and expressly assumed as part of the Assumed Contracts;

(i) any long-term debt obligations of Sellers;

(j) liabilities or obligations with respect to periods prior to the Effective Time arising under the terms of Government Payment Programs or commercial third party programs, including, without limitation, any retroactive denial of claims and civil monetary penalties;

(k) Cost Report settlement payables relating to all Cost Report periods prior to the Effective Time; and

(l) any liabilities or obligations with respect to any employees of Sellers, including liabilities under any employee health and welfare benefit plans, unemployment compensation claims, workers' compensation claims and liabilities for employee wages and benefits, except to the extent reflected in the Final Net Working Capital Amount.

1.29 "Facilities" shall mean collectively the Hospital and the other related health care facilities and assets owned and operated by Sellers, but specifically excluding any health care facilities and assets owned by the Partial Subsidiaries in which Sellers or their Affiliates own less than a majority equity or other ownership interest.

1.30 "Final Net Working Capital Amount" means the Net Working Capital Amount as of the close of business on the Closing Date.

1.31 "Financial Statements" has the meaning set forth in Section 4.4.

1.32 "Foundation" shall mean the Saint Mary's Hospital Foundation.

1.33 "GAAP" shall mean generally accepted accounting principles consistently applied.

1.34 "Governmental Entity" shall mean any executive, legislative, judicial or regulatory agency, authority, board, body, bureau, commission, court, department, directorate, instrumentality, office, official or tribunal of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision.

1.35 "Government Payment Programs" shall mean federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Entities.

1.36 "Hill-Burton Act" shall mean the Public Health Service Act, 42 U.S.C. §291, *et seq.*

1.37 "HSR Act" shall mean the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and all regulations promulgated thereunder.

1.38 "Immaterial Contract" shall mean means any Contract to which a Seller or any Affiliate thereof is a party that requires either the payment by Sellers or their Affiliate of $25,000 or less or the provision of goods or the performance of services by Sellers or any Affiliate thereof having an annual value of $25,000 or less, provided that an Immaterial Contract does not include any Contract listed on Schedule 4.8(a) of the Sellers' Disclosure Schedule.

1.39 "Indemnifying Party" has the meaning set forth in Section 12.5.

1.40 "Indemnified Party" has the meaning set forth in Section 12.5.

1.41 "Intellectual Property" has the meaning set forth in Section 4.25.

1.42 "Initial Consideration" shall mean an amount equal to **$150,000,000**.

1.43 "IRS" shall mean the Internal Revenue Service.

1.44 "Knowledge" shall mean, (a) with respect to the Sellers, (i) the actual knowledge of the Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Medical Officer, Vice President/Operations, Vice President/Human Resources and Organization Effectiveness, and Head of Corporate Compliance of Sellers and the knowledge that each such person would reasonably be expected to obtain in the course of diligently performing his or her duties for the Sellers, (ii) information in such person's files and in all written or electronic communications to or from them, and (iii) information in the minutes of the board of directors and any standing committees thereof of Sellers, and (b) with respect to Buyer, the actual knowledge of Buyer's executive officers.

1.45 "Law" shall mean, with respect to any Person, any federal, state, local or other domestic or foreign law, statute, code, rule, regulation, authorization, requirement, specification, ordinance, or restriction of any kind and any final orders, policies, decrees, consents, awards, injunctions, writs, determinations or judgments of any Governmental Entity having jurisdiction over such Person or any such Person's assets or business.

1.46 "Leased Real Property" shall mean all of the real property that is leased by Sellers or their Affiliates and used in connection with the operation of the Facilities, to the extent assignable or transferable, including, without limitation, the real property described in Schedule 1.46.

1.47 "Lien" shall mean (a) any mortgage, pledge, lien, charge, claim, restriction, reservation, condition, easement, covenant, lease, encroachment, title defect, imposition, security interest, inchoate lien, right of first refusal, option to purchase or other encumbrance of any kind, whether imposed by Law, by contract or otherwise; (b) the interest of a vendor or lessor under any conditional sale agreement, financing lease or other title retention agreement relating to such asset and (c) Contracts to create in the future any such Lien or similar arrangement.

1.48 "Losses" shall mean 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).

1.49 "Material Adverse Effect" shall mean any Effect that, individually or in the aggregate, (i) has had or would reasonably be expected to have a material adverse effect on the Purchased Assets taken as a whole or (ii) could reasonably be expected to materially impair or delay the ability of the Sellers to perform their obligations hereunder; provided, however, that none of the following shall be deemed in themselves, either alone or in combination, to constitute, and none of the following shall be taken into account in determining whether there has been, or will be, a Material Adverse Effect: (A) any Effect relating to general economic conditions in the United States or in any locations where the Sellers and their Affiliates have material operations except to the extent such Effect disproportionately affects the Sellers, their

Affiliates or the Facilities, (B) changes or proposed changes to any Law in the United States or in any location where Sellers and their Affiliates have material operations, including reimbursement rates or policies of Governmental Entities, if such change does not disproportionately affect Sellers, their Affiliates or the Facilities, (C) requirements, reimbursement rates, policies or procedures of any third party payors or accreditation commissions or organizations that are generally applicable to hospitals or health care facilities within the United States, except to the extent such requirements, reimbursement rates, policies or procedures disproportionately affects the Sellers, their Affiliates or the Facilities, (D) changes in GAAP or its application, (E) any Effect that is cured, or susceptible to cure without unreasonable efforts and is cured, by Sellers, (F) any Effect attributable to conditions that generally affect hospitals or healthcare facilities in the State of Connecticut except to the extent such Effect disproportionately affects the Sellers, their Affiliates, or the Facilities, and (G) any Effect that results from actions taken by the Sellers or their Affiliates as required by this Agreement or at the written direction of the Buyer.

1.50 "Net Working Capital Amount" shall mean the aggregate current assets of Sellers with respect to the Facilities (excluding those Excluded Assets that would otherwise be included in current assets), minus the aggregate current liabilities of Sellers with respect to the Facilities (excluding those Excluded Liabilities that would otherwise be included in current liabilities), all as determined in accordance with GAAP and, to the extent consistent with GAAP, in accordance with the principles, specifications, and methodologies set forth on Schedule 2.7, but in any case with respect to the computation of Net Working Capital Amount, (i) the following being included in current assets: Advances, usable inventories and supplies (priced at actual invoice cost), patient accounts receivable (net of allowances for contractual adjustments and uncollectibles based upon an evaluation of historical collections to gross revenues), non-patient accounts receivable as agreed, and other current assets as agreed, and (ii) the following being included in current liabilities: accounts payable, accrued expenses (excluding sales tax payable, items incurred but not recorded, and bank loans) and other current liabilities as agreed.

1.51 "Owned Real Property" shall mean all of the real property that is owned (legally or beneficially) by Sellers or their Affiliates and used in connection with the operation of the Facilities, including, without limitation, the real property described in Schedule 1.51, together with all buildings, improvements, and fixtures located thereupon, all construction in progress, and all rights, privileges, and easements appurtenant thereto.

1.52 "Partial Subsidiaries" has the meaning set forth in Section 4.31(e).

1.53 "Permits" shall mean all licenses, permits, certificates, authorizations, certificates of need, franchises, consents, accreditations and registrations, and other approvals of a Governmental Entity issued to or owned or held by Sellers, or pending, with respect to the development, ownership, and operation of the Facilities and Purchased Assets, including, without limitation, provider numbers under the Government Payment Programs and the Permits described in Schedule 1.53.

1.54 "Permitted Liens" shall mean (i) statutory liens of landlords, liens of carriers, warehousepersons, mechanics and material persons or similar liens incurred or arising

in the ordinary course of business, none of which materially detracts from the value or materially impairs the usc of the asset or property subject thereto, or materially impairs the operations of the Business, (ii) liens incurred or deposits made in connection with workers' compensation, unemployment insurance and other similar types of social security programs or to secure the performance of tenders, statutory obligations, surety and appeal bonds, bids, leases, government contracts, performance and return of money bonds and similar obligations, in each case in the ordinary course of business, consistent with past practice, (iii) liens for Taxes, assessments and governmental charges not yet due and payable, and (v) those Liens described on Schedule 1.54 as being a Permitted Lien.

1.55 "Person" shall mean a natural person, corporation, (whether for-profit or not-for-profit) limited liability company, association, joint stock company, trust, partnership, Governmental Entity, or any other legal entity or organization.

1.56 "Personal Property" shall mean all of the tangible personal property owned by Sellers or their Affiliates with respect to the operation of the Facilities, including all equipment, furniture, fixtures, machinery, vehicles, office furnishings, and leasehold improvements, a current list and the general location of which are set forth on Schedule 1.56.

1.57 "Proceeding" shall mean 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 Entity.

1.58 "Purchased Assets" shall mean all of the assets owned or used by Sellers or their Affiliates in connection with the operation of the Facilities, other than the Excluded Assets, which assets shall include, without limitation, the following:

(a) the Owned Real Property;

(b) the Personal Property;

(c) the Assumed Permits;

(d) the Sellers' Equity Interests, subject to Section 1.62;

(e) the Assumed Personal Property Leases;

(f) the Assumed Real Property Leases;

(g) the Assumed Contracts;

(h) the Advances;

(i) the Records;

(j) the Accounts Receivable;

(k) the EFT Account (other than any cash in such EFT Account at the Effective Time, which shall be an Excluded Asset);

(l) all usable inventories of supplies, drugs, food, janitorial and office supplies, and other disposables and consumables located at the Facilities, or used with respect to the operation of the Facilities (the term "usable" in this clause meaning non-obsolete and consumable within the ordinary course of business of the Facilities, consistent with past practices);

(m) the Facilities' website(s), together with the content therein, to and to the extent transferable, any Intellectual Property, including the name "Saint Mary's Hospital," and all other Intellectual Property and telephone numbers used with respect to the operation of the Facilities, all goodwill associated therewith, and all applications and registrations associated therewith;

(n) to the extent assignable by Sellers, all warranties (express or implied) and rights and claims assertable by (but not against) Sellers related to the Purchased Assets;

(o) all goodwill associated with the Facilities and the Purchased Assets;

(p) any current assets with respect to the operation of the Facilities that are not otherwise specifically described in this Section 1.58 and that are included in the Final Net Working Capital Amount;

(q) subject to Section 11.19, all insurance proceeds with respect to the Purchased Assets or the Assumed Liabilities (including insurance proceeds received by Sellers or payable to Sellers and all deductibles, copayments and self-insurance requirements payable by Sellers) arising in connection with damage to the Purchased Assets occurring on or prior to the Closing Date, to the extent not expended by Sellers for the repair or restoration of the Purchased Assets;

(r) claims of Sellers against third parties relating to the Purchased Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, other than those listed on Schedule 1.26(l) and any other claims relating to the Excluded Assets or the Excluded Liabilities;

(s) Sellers' provider agreements with Government Payment Programs;

(t) all other property, other than the Excluded Assets, of every kind, character, or description owned by Sellers and used or held for use in the Facilities, whether or not reflected on the Financial Statements, wherever located and whether or not similar to the items specifically set forth above, and all other businesses and ventures owned by Sellers in connection with the operations of the Facilities or the Purchased Assets; and

(u) the interest of Sellers in all property of the foregoing types, arising or acquired in the ordinary course of the business of Sellers with respect to the Facilities between the date hereof and the Closing.

1.59 "Purchase Price" shall mean an amount equal to the Initial Consideration as adjusted upward or downward in accordance with Section 2.7 hereof.

1.60 "Real Property" shall mean the Owned Real Property and the Leased Real Property.

1.61 "Records" shall mean, to the extent transferable under applicable Law, all documents, records, operating manuals, files, and computer software with respect to the operation of the Facilities, including, without limitation, all patient records, medical records, employee records, financial and accounting records, government required records, equipment records, construction plans and specifications, medical and administrative libraries, operating manuals, proprietary manuals, marketing materials, policy and procedure manuals, files, catalogs, data, and studies or analyses, but excluding books, documents and records relating solely to the Excluded Assets or the Excluded Liabilities.

1.62 "Sellers' Equity Interests" shall mean all of Sellers' stock, partnership, membership, or other ownership interests in each of the entities identified on Schedule 1.62 (which includes all of the Partial Subsidiaries), together with all Records relating to such entities, if any, that are in the possession of Sellers as of the Closing Date, but excluding any equity interests of any Person in SMH, Inc. For the avoidance of doubt, the membership interests of SMH, Inc. in the Harold Leever Regional Cancer Center and in the Heart Center of Greater Waterbury, Inc. are to be included in the transaction, while the equity interests of SMH, Inc. in Saint Mary's Indemnity Company, LLC and the membership interests of Saint Mary's in Saint Mary's Hospital Foundation, Inc. are to be excluded.

1.63 "Sellers' Indemnified Persons" shall mean Sellers, the Foundation and their respective Affiliates, officers, directors, stockholders, managers, employees, agents and representatives.

1.64 "Target Net Working Capital Amount" shall mean an amount equal to **$6,300,000**.

1.65 "Tax" or "Taxes" shall mean any and all taxes, charges, fees, levies, deficiencies or other assessments of any kind or description assessed by an governmental authority having jurisdiction over the Sellers, together with any interest or penalties related thereto, including, without limitation, any federal, state, local, or foreign net income, gross income, gross receipts, windfall profit, severance, property, production, sales, use, license, excise, franchise, employment, unemployment, payroll, withholding, alternative or add on minimum, ad valorem, value added, transfer, stamp, or environmental tax, escheat payments or any other tax, custom, duty, impost, levy, governmental fee or other like assessment or charge.

1.66 "Termination Fee" has the meaning set forth in Section 11.1(b).

1.67 "Title Commitment" has the meaning set forth in Section 7.3.

1.68 "Title Company" has the meaning set forth in Section 7.3.

1.69 "Title Policy" has the meaning set forth in Section 7.3.

1.70 "Transaction Documents" shall mean this Agreement, the Bill of Sale, the Assignment and Assumption Agreement, Assignment and Assumption of Leases and any other document, certificate or instrument delivered pursuant hereto.

1.71 "Transfer Act" shall mean the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*, as the same may be amended after the date hereof.

1.72 "WARN Act" shall mean the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq.*

ARTICLE II
PURCHASE AND SALE OF PURCHASED ASSETS; OTHER AGREEMENTS

2.1 Purchase and Sale of Purchased Assets. At the Closing and upon all of the terms and subject to all of the conditions of this Agreement:

(a) Sellers shall sell, assign, convey, and deliver to Buyer, and Buyer shall purchase and accept from Sellers, the Purchased Assets free and clear of all Liens other than Permitted Liens; and

(b) From and after the Closing, the Sellers shall retain the Excluded Assets.

2.2 Assumption of Assumed Liabilities; No Assumption of Excluded Liabilities. As of the Effective Time, Buyer will assume the Assumed Liabilities. The Buyer will not assume, and Sellers shall remain responsible for and shall promptly pay, perform and discharge, all of the Excluded Liabilities.

2.3 Payment of Purchase Price.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Sellers in this Agreement, and as consideration for the sale of the Purchased Assets, Buyer shall tender the Purchase Price, subject to the adjustments described in this Section 2.3(a). Accordingly, on the Closing Date, Buyer shall pay Sellers the Purchase Price (i.e., the Initial Consideration, as adjusted pursuant to Section 2.7(b)), minus (i) the agreed-upon value of any capital leases and pension liabilities (as determined in accordance with Section 2.3(b)), minus (ii) liabilities of Sellers (if any) related to the Retiree Medical Plan; minus (iii) in the event Sellers are unable to assign and transfer to Buyer or Buyer's designee all of Seller's Equity Interests, an amount equal to the consideration received by Sellers from a third party in a bona fide, arms-length sale in the event such third party has exercised a right of first refusal or similar contractual right to purchase such Equity Interest from Sellers (the parties shall agree separately in writing as to an appropriate reduction relating to any of Seller's Equity Interests that are not transferred to Buyer or Buyer's designee at the Closing); and (iv) as adjusted by the parties' good faith estimate as of the Closing Date of the amount of the

prorations to be made pursuant to Section 2.5, by wire transfer of immediately available funds to an account designated by the Sellers to the Buyer prior to the Closing Date. The Purchase Price as so adjusted shall be subject to further adjustment after the Closing in accordance with Section 2.7 to reflect the Final Net Working Capital Amount and shall be disposed of by Sellers in accordance with Schedule 2.3.

(b) Within 30 days prior to the Closing Date, Sellers' actuary (Deloitte & Touche) and Buyer's actuary (Milliman) shall each perform a valuation of Sellers' pension plan liability. In the event that the valuations are within **15%** of one another, they shall be averaged, which average shall be used as the "pension liabilities" in Section 2.3(a)(i). In the event that the two valuations are not within **15%** of one another, Deloitte and Milliman shall be instructed to retain a third independent valuation firm to perform a valuation of Sellers' pension plan liability and an average will be taken of the two valuations, out of Deloitte's, Milliman' s and the third independent valuation firms, that are closest in value, which average shall in such instance be used as the "pension liabilities" in Section 2.3(a)(i). The parties would share equally the cost of any third independent valuation firm.

2.4 Allocation of Purchase Price. Within a reasonable time after Closing, Buyer shall provide Sellers a proposed allocation of the Purchase Price among the Facilities and the Purchased 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 sixty (60) days after Buyer provides the proposed allocation to Sellers unless Sellers object to the proposed allocation, in which case Sellers shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within sixty (60) days after Sellers give their objection to Buyer. If a final resolution is not reached within sixty (60) days after Sellers have submitted their objection in writing, Buyer and Sellers shall utilize the dispute mechanism described in Section 2.7(d), and the determination of the Accounting Firm shall be binding on the parties hereto. Buyer and Sellers agree to be bound by the allocations determined hereunder (for federal and state Tax purposes) and shall account for and report the transactions contemplated by this Agreement in accordance with such allocations, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation unless required to do so by applicable Law. Sellers and Buyer shall exchange IRS Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the IRS in accordance with such allocation. Notwithstanding the foregoing, not later than 15 days prior to the Closing, Buyer shall propose a provisional allocation of the Purchase Price to the Real Property for the purpose of obtaining a Title Commitment in accordance with Section 7.3, which provisional allocation shall be subject to revision in accordance with the terms of this Section 2.4.

2.5 Prorations.

(a) To the extent not included in the Net Working Capital Amount, all Taxes and other assessments, payments for Leased Real Property and Personal Property leases, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern or that have been prepaid with respect to the Purchased Assets, including any special assessments, shall be prorated as of the Effective Time. Sellers shall be responsible for that portion of such prorated items attributable to the period ending as of the Effective Time, and

Buyer shall be responsible for that portion of such prorated items attributable to the period beginning as of the Effective Time. Any such prepaid items attributable to the period beginning as of the Effective Time shall be a Purchased Asset hereunder.

(b) Any Advances existing as of the Effective Time shall be a Purchased Asset hereunder.

(c) If the actual amount of any prorated item or Advances identified above is not known at the time of the Closing, the proration shall be based upon 100% of the Tax, expense amount or Advance incurred in the most recent billing period, for Taxes, expenses and Advances billed less often than quarterly, and upon 100% of the average expense incurred in the preceding three billing periods for all other Taxes, expenses and Advances.

2.6 Retention of Copies. From and after the Closing Date, the Sellers may retain, at their expense, one archival copy of all Records and other documents or materials conveyed hereunder.

2.7 Working Capital Adjustment.

(a) Determination of the Estimated Net Working Capital Amount. At least ten (10) Business Days prior to Closing, Sellers shall deliver to Buyer a reasonable estimate of the Net Working Capital Amount of Sellers as of immediately prior to the Effective Time containing reasonable detail and supporting documents showing the derivation of such estimate (the "Estimated Net Working Capital Amount"). The principles, specifications, and methodologies for determining the Estimated Net Working Capital Amount shall be specified in Schedule 2.7. As promptly as practicable but no later than three (3) Business Days prior to Closing, Buyer shall identify any adjustments that it believes are required to the Estimated Net Working Capital Amount. If Sellers dispute any such adjustment, Buyer and Sellers shall use their commercially reasonable efforts to resolve such dispute, after which Sellers shall re-deliver to Buyer a statement of the Estimated Net Working Capital Amount with such adjustment as Buyer and Sellers have agreed is appropriate. If Sellers and Buyer are unable to resolve a dispute with respect to the Estimated Net Working Capital Amount prior to the Closing, Buyer shall not be deemed to have waived its objections to the Estimated Net Working Capital Amount and shall resolve any disputes related to the Estimated Net Working Capital Amount in, or prior to the determination of, the Final Net Working Capital Amount.

(b) Adjustment of Purchase Price Based on Estimated Net Working Capital. If the Estimated Net Working Capital Amount exceeds the Target Net Working Capital Amount, then the Purchase Price to be paid by Buyer to Sellers at the Closing shall be determined by increasing the Initial Consideration by such excess amount. If the Estimated Net Working Capital Amount is less than the Target Net Working Capital Amount, the Purchase Price to be paid by Buyer to Sellers at the Closing shall be determined by decreasing the Initial Consideration by the amount of such deficit.

(c) Final Determination of Net Working Capital. Within ninety (90) days after the Closing, Buyer shall deliver to Sellers its determination of the Final Net Working Capital Amount (following the same principles, specifications, and methodologies used to

determine the Estimated Net Working Capital Amount as set forth on Schedule 2.7). Sellers shall have reasonable access to the financial books and records of Buyer pertaining to the Facilities to confirm or audit Buyer's working capital computations. Should Sellers agree with Buyer's determination of the Final Net Working Capital Amount, they shall promptly notify Buyer of the same and Buyer's determination of the Final Net Working Capital Amount shall be considered the Final Net Working Capital Amount for purposes of this Section 2.7. Should Sellers disagree with Buyer's determination of the Final Net Working Capital Amount, they shall notify Buyer within sixty (60) days after Buyer's delivery of its determination of the Final Net Working Capital Amount; if no notice shall be delivered by Sellers to Buyer within such sixty (60) day period, Sellers will be deemed to have agreed with Buyer's determination of the Final Net Working Capital Amount. If Sellers and Buyer agree on the Final Net Working Capital Amount, the agreed upon amount shall be considered the Final Net Working Capital Amount for purposes of this Section 2.7. If Sellers and Buyer fail to agree within thirty (30) days after Sellers' delivery of notice of disagreement on the Final Net Working Capital Amount, such disagreement shall be resolved in accordance with the procedure set forth in Section 2.7(d).

(d) Dispute of Adjustments. In the event that Sellers do not agree with Buyer's determination of the Final Net Working Capital Amount and Sellers and Buyer are not able to agree on the determination of Final Net Working Capital Amount within thirty (30) days after Sellers' delivery of a notice of disagreement, Sellers and Buyer each shall have the right to require that such disputed determination be submitted to an independent certified public accounting firm mutually selected by Buyer and Sellers (the "Accounting Firm") for computation or verification in accordance with the provisions of this Agreement. The Accounting Firm shall review the matters in dispute and, acting as arbitrators, shall promptly decide the proper amounts of such disputed entries (which decision shall also include a calculation of the Final Net Working Capital Amount). The submission of the disputed matter to the Accounting Firm shall be the exclusive remedy for resolving accounting disputes relative to the determination of the Final Net Working Capital Amount. The Accounting Firm's determination of the Final Net Working Capital Amount shall be binding upon Sellers and Buyer and shall be considered the Final Net Working Capital Amount for purposes of this Section 2.7. The Accounting Firm's fees and expenses shall be borne equally by Sellers and Buyer.

(e) Required Payments. Within five (5) Business Days after the determination of the Final Net Working Capital Amount, if the Final Net Working Capital Amount exceeds the Estimated Net Working Capital Amount, then the amount of such excess shall be paid by wire transfer of immediately available funds by Buyer to Sellers and if the Final Net Working Capital Amount is less than the Estimated Net Working Capital Amount, then the amount of such deficit shall be paid by wire transfer of immediately available funds by Sellers to Buyer.

(f) Physical Inventory. If requested by Buyer at least ten (10) Business Days prior to the Closing, Sellers shall cause a physical inventory to be taken of the inventory and supplies on hand at the Facilities by either (i) employees or representatives of Sellers at the Facilities or their Affiliates or (ii) an independent third party selected by Buyer, the cost of which independent third party shall be borne by Buyer, as near in time as possible to the Closing and with the results extended and adjusted through the Effective Time. It shall be in Buyer's sole discretion as to whether employees or representatives of Sellers at the Facilities or

an independent third party are used to conduct such physical inventory. Sellers shall permit representatives or employees of Buyer to observe such inventory process. All inventory items shall be valued at the lower of cost or market on a first-in first-out basis. The parties acknowledge that the inventory to be taken pursuant to this Section 2.7(f) shall not be conducted until immediately prior to the Closing and, as such, the results of such inventory may not be available until sometime after the Closing. Accordingly, the parties agree that for purposes of determining the Estimated Net Working Capital Amount, inventory with respect to the operation of the Facilities shall be valued as reflected by the latest available unaudited balance sheet of Sellers with respect to the Facilities if the results of such inventory are not available. For purposes of determining the Final Net Working Capital Amount, inventory shall be valued as determined pursuant to this Section 2.7(f).

2.8 Disclaimer of Warranties. Except as expressly set forth in Article IV hereof and Sellers' representations and warranties set forth in the other Transaction Documents, the Purchased Assets will be transferred in their physical condition at the Effective Time, "AS IS, WHERE IS, AND WITH ALL FAULTS AND NONCOMPLIANCE WITH LAWS," WITH NO WARRANTY OF HABITABILITY OR FITNESS FOR HABITATION with respect to the Real Property, and WITH NO WARRANTIES, INCLUDING, WITHOUT LIMITATION, THE WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, with respect to the physical condition of the Personal Property and the inventory and supplies.

ARTICLE III
CLOSING

3.1 Closing. Subject to the satisfaction or waiver by the appropriate party of all of the conditions precedent to Closing specified in Article VIII and Article IX hereof, the consummation of the transactions contemplated by and described in this Agreement (the "Closing") shall take place at the offices of Brown Rudnick LLP, 185 Asylum Street, Hartford, Connecticut 06103, at 10:00 a.m., local time, on the Closing Date.

3.2 Actions of Sellers at Closing. At the Closing and unless otherwise waived in writing by Buyer, Sellers shall deliver to Buyer the following:

(a) Special warranty deeds, fully executed by the applicable Seller in recordable form, conveying to the Buyer good and marketable fee title to the Owned Real Property, free and clear of any Liens except Permitted Liens;

(b) A Bill of Sale, fully executed by the applicable Seller, conveying to the Buyer good and marketable title to all Personal Property owned by such Seller that is a part of the Purchased Assets and valid title to all intangible assets, including Intellectual Property, owned by such Seller that are a part of the Purchased Assets, free and clear of all liabilities and Liens, other than the Assumed Liabilities and Permitted Liens;

(c) An Assignment and Assumption Agreement, fully executed by the applicable Seller, conveying to Buyer such Seller's interest in the Assumed Contracts (except for the Assumed Contracts assigned pursuant to the Assignment and Assumption of Leases);

(d) An Assignment and Assumption of Leases, fully executed by the applicable Seller, assigning to the Buyer leasehold title to the Leased Real Property, in each case subject only to any Permitted Liens;

(e) All instruments, documents, rent rolls and affidavits required by the Title Company to issue the Title Policy as described in and provided by Section 7.3 hereof that are consistent with the Connecticut Standards of Title or that may be reasonably necessary to consummate the transactions contemplated by this Agreement;

(f) A copy of resolutions duly adopted by the Board of Directors of each Seller, authorizing and approving the transactions contemplated hereby and the execution and delivery of the Transaction Documents to which such Seller is a party, certified as true and in full force and effect as of the Closing, by an appropriate officer or other representative of such Seller;

(g) A certificate of the President or a Vice President of each Seller, certifying that each covenant and agreement of such Seller to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of such Seller is true and correct on the Closing Date, as if made on and as of the Closing Date;

(h) A certificate of incumbency for the officers or representatives of each Seller executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(i) A certificate of existence and good standing of each Seller and each entity that operates the Facilities from the State of Connecticut, dated the most recent practical date prior to the Closing;

(j) All certificates of title, stock certificates and other documents evidencing an ownership interest conveyed as part of the Purchased Assets (including in Sellers' Equity Interests being conveyed);

(k) An affidavit stating that each Seller is not a "foreign person" as defined in Section 1445(f)(3) of the Code, as amended;

(l) Final execution copy of any Transfer Act Form and Environmental Condition Assessment Form ("ECAF"), as more fully described in Section 11.15;

(m) An original or certified copy of the tail insurance policies required by Section 6.7 and receipts evidencing the payment of the premiums therefor;

(n) A list of source or access codes to computers, combinations to safes and the location of and keys to safe deposit boxes, if any, to the extent that the foregoing are included in the Purchased Assets;

(o) UCC termination statements or other releases for all Liens on the Purchased Assets not constituting Permitted Liens, which termination statements and releases will be effective as of Closing;

(p) Limited powers of attorney to permit Buyer to utilize the Hospital's DEA registration numbers, in substantially the form of Exhibit 4 attached hereto, fully executed by SMH, Inc.;

(q) All necessary state and local real estate conveyance Tax forms duly executed by Sellers; and

(r) Such other instruments and documents as Buyer reasonably deems necessary to effect the transactions contemplated hereby.

3.3 Actions of Buyer at Closing. At the Closing and unless otherwise waived in writing by Sellers, Parent or Buyer, as applicable, shall deliver to Sellers the following:

(a) An amount equal to the Purchase Price, as adjusted pursuant to Section 2.3, in immediately available funds;

(b) The Assignment and Assumption Agreement, fully executed by Buyer;

(c) The Assignment and Assumption of Leases, fully executed by Buyer;

(d) A copy of resolutions duly adopted by the Board of Directors (or similar governing body) of each of Parent and Buyer authorizing and approving the performance of the transactions contemplated hereby and the execution and delivery of this Agreement and the documents described herein, certified as true and in full force as of the Closing, by an appropriate officer of Parent and Buyer, respectively;

(e) A certificate of the President or a Vice President (or similar officer or member) of Buyer, certifying that each covenant and agreement of Buyer to be performed prior to or as of the Closing pursuant to this Agreement has been performed and each representation and warranty of Buyer is true and correct on the Closing Date, as if made on and as of the Closing Date;

(f) A certificate of incumbency for the respective officers (or managers or members) of Parent and Buyer executing this Agreement and any other agreements or instruments contemplated herein or making certifications for the Closing, dated as of the Closing Date;

(g) A certificate of existence and good standing of Parent and Buyer from the State of Delaware, dated the most recent practical date prior to Closing; and

(h) Such other instruments and documents as Sellers reasonably deem necessary to effect the transactions contemplated hereby.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF SELLERS

As of the date hereof and as of the Closing Date, subject to such exceptions as are disclosed in the disclosure schedule supplied by Sellers to Buyer dated as of the date hereof (the "Sellers' Disclosure Schedule"), which Sellers' Disclosure Schedule identifies the Section (or, if applicable, subsection) to which such exception relates (provided, however, that such disclosure shall also apply to particular matters represented or warranted in other Sections and subsections to the extent that it is readily apparent from the text of such disclosure) and which Sellers' Disclosure Schedule is subject to updating between the date hereof and the Closing Date in accordance with the provisions of Section 13.1 hereof, Sellers, jointly and severally, represent and warrant to Buyer as follows:

4.1 Existence and Capacity. Each Seller is a not-for-profit corporation, duly organized, validly existing, and in good standing under the laws of the State of Connecticut. Each Seller is licensed, qualified or admitted to do business in the State of Connecticut, and there is no other jurisdiction in which the ownership, use or leasing of such Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary. Sellers have the requisite power and authority to enter into this Agreement, to perform their obligations hereunder, and to conduct their business as now being conducted.

4.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance by Sellers of the Transaction Documents and all other agreements referenced herein, or ancillary hereto, to which Sellers are a party, and the consummation by Sellers of the transactions contemplated by this Agreement and the other Transaction Documents, as applicable:

(a) are within their corporate powers, are not in contravention of the terms of their organizational documents, and have been duly authorized by all appropriate corporate action;

(b) except as provided in Schedule 4.2(b) of the Sellers' Disclosure Schedule, do not require any approval or consent of, or filing with, any Governmental Entity bearing on the validity of this Agreement that is required by Law;

(c) except as set forth in Schedule 4.2(c) of the Sellers' Disclosure Schedule, will not conflict with, result in any breach or contravention of, or the creation of any Lien under any Contract to which either Seller is a party or by which either Seller is bound, except for such breaches or contraventions that may result from the failure to obtain the consent of the counterparty thereto in connection with the assignment of any Assumed Contract to the Buyer and for which Sellers remains liable; and

(d) will not violate any Law to which Sellers or the Purchased Assets may be subject.

4.3 Binding Agreement. This Agreement and the other Transaction Documents to which Sellers are a party are and will constitute the valid and legally binding

obligations of Sellers, and are and will be enforceable against Sellers in accordance with the respective terms hereof or thereof, subject, to (a) applicable bankruptcy, reorganization, insolvency, moratorium, and other Laws affecting creditors' rights generally from time to time in effect and (b) limitations on the enforcement of equitable remedies.

4.4 Financial Statements. Sellers have delivered to Buyer copies of the following financial statements with respect to the Facilities (collectively, the "Financial Statements"), which Financial Statements are maintained on an accrual basis, and copies of which are attached hereto as Schedule 4.4 of the Sellers' Disclosure Schedule:

(a) Unaudited Balance Sheet dated as of May 31, 2014 (the "Balance Sheet Date");

(b) Unaudited Income Statement for the [_____]-month period ended on the Balance Sheet Date; and

(c) Audited Balance Sheets, Income Statements, and Statements of Cash Flows for the fiscal years ended September 30, 2011, 2012 and 2013.

Such unaudited Financial Statements conform to GAAP consistently applied, except as set forth on Schedule 4.4 of the Sellers' Disclosure Schedule. Such audited Financial Statements have been prepared in accordance with GAAP, applied on a consistent basis throughout the periods indicated. Such Balance Sheets present fairly the financial condition of Sellers with respect to the Facilities as of the dates indicated thereon, and such Income Statements present fairly the results of operations of Sellers with respect to the Facilities for the periods indicated thereon.

4.5 Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, Sellers do not have any liabilities or obligations of any nature whatsoever with respect to the Facilities or the Purchased 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 consistent with past practice since the Balance Sheet Date, and none of which could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Effect.

4.6 Certain Post-Balance Sheet Results. Except as set forth in Schedule 4.6 of the Sellers' Disclosure Schedule, since September 30, 2013, there has not been any:

(a) material damage, destruction, or loss (whether or not covered by insurance) affecting the Facilities or the Purchased Assets;

(b) Material Adverse Effect with respect to the Purchased Assets or the operation of the Facilities;

(c) threatened employee strike, material work stoppage, or material labor dispute pertaining to the Facilities;

(d) sale, assignment, transfer, or disposition of any Purchased Asset, or any agreement to do the same, except in the ordinary course of business consistent with past practice, with comparable replacement thereof;

(e) any general increase in the compensation payable by Sellers with respect to the Facilities to any of its or their employees or independent contractors or any increase in, or institution of, any bonus, insurance, pension, profit-sharing or other employee benefit plan, remuneration, or arrangements made to, for, or with such employees except in the ordinary course of business, consistent with past practice;

(f) change in the composition of the medical staff of the Facilities, other than normal turnover occurring in the ordinary course of business, consistent with past practice;

(g) change in the rates charged by the Facilities for their services, other than those made in the ordinary course of business, consistent with past practice;

(h) sale, factor, adjustment or write-off of Accounts Receivable, or any agreement to do the same, or reduction in reserves for Accounts Receivable outside the ordinary course of business, consistent with past practice;

(i) Lien imposed on any of the Purchased Assets, or any agreement to do the same;

(j) cancellation or waiver by Sellers of any material rights with respect to the Purchased Assets or the Facilities, except in the ordinary course of business, or any agreement to do the same;

(k) other than compensation paid in the ordinary course of employment, payments to, sale of any Purchased Assets to, or entrance into any Contract with any officer, director, or trustee of Sellers or their Affiliates, or with any Affiliate of any such Person;

(l) payments to or agreements made to pay to any Person any damages, fines, penalties or other amounts with respect to an actual or alleged violation of any Law;

(m) institution of any new, or termination or amendment of any existing, employee benefit plan, except for amendments required to comply with applicable Law;

(n) change in the accounting methods or practices employed by Sellers with respect to the Facilities, other than those required by any changes in GAAP; or

(o) any other transaction, or agreement to enter into any other transaction, pertaining to the Facilities or Purchased Assets by Sellers or their Affiliates, outside the ordinary course of business (other than the transactions contemplated by this Agreement).

4.7 Licenses. Each of the health care facilities comprising the Facilities is duly licensed pursuant to the applicable Laws of the State of Connecticut. The pharmacies, laboratories, and all other ancillary departments located at the Facilities or operated for the benefit of the Facilities that are required to be specially licensed are duly licensed by the Connecticut Department of Public Health or other appropriate licensing agency (the "State Health Agency"). Sellers have all other material Permits that are needed or required by Law to operate the businesses related to or affecting the Purchased Assets and Facilities or any ancillary services related thereto. Sellers have delivered to Buyer an accurate list and summary description (Schedule 4.7 of the Sellers' Disclosure Schedule) of all such Permits relating to the operation of the Facilities or the Purchased Assets, all of which are now and as of the Closing shall be in good standing, except as disclosed on Schedule 4.7 of the Sellers' Disclosure Schedule. Sellers have not received any written notice from any Governmental Entity relating to the threatened, pending, or possible revocation, termination, suspension or limitation of any such material Permits.

4.8 Agreements and Commitments.

(a) Schedule 4.8(a) of the Sellers' Disclosure Schedule identifies an accurate list of all Contracts to which Sellers are a party or by which Sellers, the Facilities, the Purchased Assets or any portion thereof is bound in the categories below:

(i) Contracts that relate to the ownership or use of, title to or interest in Real Property;

(ii) Contracts with (A) a provider or provider group, (B) an immediate family member of a provider on the medical staff of the Hospital or (C) any Person that provides marketing services on an on-going basis for Sellers;

(iii) Contracts relating to Intellectual Property and information systems;

(iv) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;

(v) Contracts with directors, trustees, officers, employees, or other agents of Sellers or their Affiliates;

(vi) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Sellers (or any subsidiary of Sellers which operates the Facilities) of any lawful business;

(vii) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;

(viii) Contracts relating to the administration, operation or funding of any employee benefit plan;

(ix) Contracts between Sellers and any of the Partial Subsidiaries;

(x) Contracts with Governmental Entities;

(xi) Contracts providing for payments based in any manner on the revenue or profits of the Facilities or the Purchased Assets;

(xii) loan agreements, bonds, mortgages, liens, or other security agreements;

(xiii) equipment and other leases that are capital leases; and

(xiv) all other Contracts which require payment by Sellers of amounts in excess of $100,000 after the date of this Agreement, unless Sellers may terminate the Contract, without cause, within ninety (90) days and all payments due by Sellers under the Contract through the date of such termination equal, in the aggregate, less than $100,000 (including any penalty or termination fee).

(b) Sellers have made available to Buyer true and correct copies of each Contract listed on Schedule 4.8(a) of the Sellers' Disclosure Schedule. The Assumed Contracts constitute valid and legally binding obligations of Sellers and, to the Knowledge of Sellers, each other party thereto, and are enforceable against Sellers, and, to the Knowledge of Sellers, against each other party thereto, in accordance with their terms. Each Assumed Contract constitutes the entire agreement between the respective parties thereto with respect to the subject matter thereof. All obligations required to be performed under the terms of the Assumed Contracts by Sellers and, to the Knowledge of Sellers, each other party thereto have been performed, no material breach has occurred under any of the Assumed Contracts, no act or omission by Sellers has occurred that, with the giving of notice, the lapse of time, or both, would constitute a material default under the Assumed Contracts, and each of such Assumed Contracts is now in full force and effect. Except as expressly set forth on Schedule 4.8(b) of the Sellers' Disclosure Schedule, none of the Assumed Contracts requires consent to the assignment and assumption of such Assumed Contracts by Buyer. Except as expressly set forth on Schedule 4.8(b) of the Sellers' Disclosure Schedule, the assignment of the Assumed Contracts to and assumption of such Assumed Contracts by Buyer will not give a third party the right to terminate or modify such Contract, or result in any penalty or premium thereunder.

4.9 Medicare Participation/Accreditation. The Hospital participates in the Government Payment Programs, has a current and valid provider contract with such programs, is in compliance with the conditions of participation in such programs, and has received all approvals or qualifications necessary for capital reimbursement for the Hospital. The Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and is not subject to any material withholds or offsets in respect thereof. To Sellers' Knowledge, all Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by Sellers under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Sellers or their Affiliates, and no such incentive payments were remitted

due to any fraudulent, negligent or unlawful act or omission of Sellers or their Affiliates. The Hospital is duly accredited, with no contingencies, by The Joint Commission (the "Joint Commission") for the three (3) year period set forth on Schedule 4.9 of the Sellers' Disclosure Schedule. A copy of the most recent accreditation letter from The Joint Commission pertaining to the Hospital has been made available to Buyer. Sellers have delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction required or submitted by Sellers since January 1, 2012. Sellers have taken or are taking all reasonable steps to correct all material deficiencies noted therein. Schedule 4.9 of the Sellers' Disclosure Schedule includes a list and description of all unexpected occurrences involving death or serious physical or psychological injury, since January 1, 2012. Sellers and their officers, directors, managing employees, or controlling shareholders are not excluded from participation in the Government Payment Programs, and Sellers have not received any written notice that any such exclusion is threatened. Except as set forth in a writing delivered by Sellers to Buyer or as set forth on Schedule 4.9 of the Sellers' Disclosure Schedule, Sellers have not received any written notice from any of the Government Payment Programs or any other third party payor programs of any pending or threatened investigations or surveys, and to the Knowledge of Sellers, no such investigations or surveys are pending or threatened. Sellers have registered with the QNet Exchange ("QNet") as required by The Centers for Medicare and Medicaid Services ("CMS") under its Hospital Quality Initiative Program (the "HQI Program"). The Hospital 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 in accordance with applicable reporting deadlines and in the form and manner required by CMS and The Joint Commission, respectively. Sellers have not received written 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. Sellers have 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.

4.10 Regulatory Compliance. Except as set forth in a writing delivered by Sellers to Buyer or as set forth on Schedule 4.10 of the Sellers' Disclosure Schedule, the operations of the Facilities and the Purchased Assets comply in all material respects with all applicable Laws of all Governmental Entities. Sellers have timely filed all reports, data, and other information required to be filed with any Governmental Entity. To the Knowledge of Sellers, Sellers have not committed a violation of federal or state Laws regulating health care fraud, including but not limited to the federal Anti-Kickback Law, 42 U.S.C. §1320a-7b, the Stark Laws, 42 U.S.C. §1395nn, as amended, and the False Claims Act, 31 U.S.C. §3729, *et seq*. The Facilities are in compliance in all material respects with the administrative simplification provisions required under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), including the electronic data interchange regulations and the health care privacy regulations, as of the applicable effective dates for such requirements.

4.11 Equipment. Sellers have delivered to Buyer a depreciation schedule as of the Balance Sheet Date (Schedule 4.11 of the Sellers' Disclosure Schedule) that takes into

consideration all the equipment associated with, or constituting any part of, the Facilities and the Purchased Assets. All such equipment is useable for its intended purposes in the ordinary course of business of the Facilities and is in working condition, subject to reasonable wear and tear. Since the Balance Sheet Date, Sellers have not sold or otherwise disposed of any item of equipment having a net book value in excess of One Hundred Thousand Dollars ($100,000) associated with, or constituting any part of, the Facilities and the Purchased Assets, except in the ordinary course of business or unless replaced by comparable replacement equipment.

4.12 Real Property. Sellers or their Affiliates own good and marketable fee simple and/or leasehold title, as the case may be, to the Real Property, together with all buildings, improvements, and component parts thereon and all appurtenances and rights thereto. The Real Property will be conveyed to the Buyer free and clear of any and all Liens, except the Permitted Liens. With respect to the Real Property, except as set forth in Schedule 4.12 of the Sellers' Disclosure Schedule:

(a) Sellers have not received during the past five (5) years written notice of a violation of any applicable Law or requirement relating to the operation of Real Property;

(b) The Real Property and its operation are in compliance in all material respects with all applicable zoning ordinances, and the consummation of the transactions contemplated herein will not result in a violation of any applicable zoning ordinance or the termination of any applicable zoning variance now existing, and the buildings and improvements constituting the Real Property comply in all material respects with all building codes. To Sellers' Knowledge, (i) the buildings, structures and facilities standing on the Real Property are structurally sound and in need of no material maintenance or repairs, except for ordinary, routine maintenance, and (ii) no part of the 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 Laws pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction);

(c) The Real Property is subject to no Liens or other limitations on title that could make such property unusable for its current use or the title uninsurable or unmarketable or that materially restrict or impair the use, marketability, or insurability of the Real Property other than the Permitted Liens;

(d) Except as set forth on Schedule 4.12, all of the Real Property currently in use for the operations of the Facilities is in compliance in all material respects with the applicable provisions of the Rehabilitation Act of 1973, Title III of the Americans with Disabilities Act, and the provisions of any comparable state statute relative to accessibility (these Laws are referred to, collectively, as the "Accessibility Laws"), and there is no pending, noticed, or, to the Knowledge of Sellers, threatened Proceeding or complaint (whether from a Governmental Entity or from any other Person) relating to compliance of any of the Real Property with the Accessibility Laws;

(e) There are no tenants or other Persons occupying any space in the Real Property other than pursuant to tenant leases described in Schedule 4.12 of the Sellers' Disclosure Schedule, and no tenants have paid rent in advance for more than one month and no improvement credit or other tenant allowance of any nature is owed to any tenant, nor is any landlord improvement work required, except as disclosed in Schedule 4.12 of the Sellers' Disclosure Schedule;

(f) Attached to Schedule 4.12 of the Sellers' Disclosure Schedule is a "rent roll" that sets forth for those leases where Sellers with respect to the Facilities is landlord: (i) the names of then current tenants; (ii) the rental payments for the then current month under each of the leases; (iii) a list of all then delinquent rental payments; (iv) a list of all concessions granted to tenants; (v) a list of all tenant deposits and a description of any application thereof; (vi) the dates that each of the leases commenced and will expire; (vii) the square footage of any such space leased pursuant to the respective lease; (viii) any renewal options available to tenants under the leases; and (ix) a list of all uncured material defaults under the leases known to Sellers;

(g) Sellers have not received written or posted notice of condemnation or of any special assessment relating to any part of the Real Property, of any existing or proposed plans to modify or realign any street or highway, or any existing or proposed eminent domain proceeding by any Governmental Entity that would result in the taking of all or any part of the Real Property or that would adversely affect the current use of any part of the Real Property;

(h) To the Knowledge of Sellers, all permanent certificates of occupancy and all other material Permits required by all Governmental Entities having jurisdiction and the requisite certificates of the local board of fire underwriters (or other body exercising similar functions) have been issued for the Real Property (and all individual items constituting the Real Property), have been paid for, are in full force and effect, and will not be invalidated, violated, or otherwise adversely affected by the transfer of the Real Property to the Buyer;

(i) To the Knowledge of Sellers, water, sanitary sewer, storm sewer, drainage, electric, telephone, gas, and other public utility systems are available to the Real Property, as currently developed, and are directly connected to the lines and/or other facilities of the respective public authorities or utility companies providing such services or accepting such discharge, either adjacent to the Real Property or through easements or rights of way appurtenant to and forming a party of the Real Property; and, to the Knowledge of Sellers, such easements or rights-of-way have been fully granted, all charges therefor have been fully paid by Sellers, and all charges for the aforesaid utility systems and the connection of the Real Property to such systems, including without limitation connections fees, "tie-in" charges, and other charges now or hereafter to become due and payable, have been fully paid by Sellers; and the water and sanitary sewer service described above is supplied by public authority; and

(j) The Owned Real Property described on Schedule 1.51 constitutes all of the Real Property owned by Sellers or any Affiliate of Sellers that is associated with or employed in the operation of the Facilities and the Leased Real Property described on Schedule 1.46 constitutes all of the Real Property leased by Sellers or any Affiliate of Sellers that is associated with or utilized in the operation of the Facilities.

4.13 Title. Except as provided in Schedule 4.13 of the Sellers' Disclosure Schedule, Sellers or their Affiliates own, and at Closing will transfer to Sellers, good, valid, and marketable title to all of the Purchased Assets, subject to no Lien other than the Permitted Liens and the Assumed Liabilities.

4.14 Employee Benefit Plans.

(a) Schedule 4.14 of the Sellers' Disclosure Schedule contains a list of all benefit plans maintained by Sellers within the last three (3) years with respect to Sellers' employees at the Facilities (whether tax-qualified or nonqualified, currently effective or terminated, written or unwritten) including, without limitation, any of the following:

(i) employee pension benefit plan (as defined in Section 3(2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA")), including, without limitation, any pension, profit-sharing, or stock bonus plan (as described in Section 401(a) of the Code, and related provisions thereof), defined benefit plan or defined contribution plan (as defined in ERISA Sections 3(34) and 3(35), respectively) or church plan (as defined in ERISA Section 3 (33));

(ii) annuity contracts purchased by Sellers for the benefit of employees at the Facilities in accordance with Code Section 403(b) including, without limitation, any group annuity contracts, individual annuity contracts, and custodial account arrangements under Code Section 403(b)(7), regardless of whether contributions are made to such annuity contracts on a pre-tax or after-tax basis;

(iii) material employee welfare benefit plan (as defined in ERISA Section 3(1)) including, without limitation, any health (including, without limitation, medical, dental, or vision) plan, life-insurance plan, death benefit plan, short-term disability plan, long-term disability plan, accident plan, accidental death and dismemberment plan, long-term care plan, or employee assistance plan;

(iv) material fringe benefit plan, including, without limitation, any specified fringe benefit plan (as defined in Code Section 6039D), cafeteria plan, or tuition assistance plan;

(v) material executive compensation or incentive plan, including, without limitation, any bonus plan, incentive-compensation plan, deferred-compensation plan, non-qualified profit-sharing plan, stock-option plan, stock-appreciation-right plan, stock-bonus plan, stock-purchase plan, employee-stock-ownership plan, or savings plan;

(vi) post-termination benefits plan including, without limitation, any severance plan, change-in-control plan, supplemental-unemployment plan, or retiree medical plan;

(vii) vacation, holiday, sick-leave, paid-time-off, or other employee compensation plan, procedure, program, payroll practice, policy, agreement, commitment, contract, or understanding; or

(viii) any trust, escrow, or other agreement related to any employee pension benefit plan that (i) is maintained or contributed to by Sellers or any other corporation or trade or business controlled by, controlling, or under common control with Sellers (within the meaning of Code Section 414 or ERISA Sections 4001(a)(14) or 4001(b)) ("ERISA Affiliate"), or with respect to which Sellers or any ERISA Affiliate has or may reasonably expect to have any liability; or (ii) or any other material arrangement that provides benefits, or describes a plan, procedure, program, payroll practice, policy, agreement, commitment, contract, or understanding applicable to any current or former director, officer, employee, or service provider of Sellers, or the dependents of any thereof, regardless of how (or whether) liabilities for the provision of benefits are accrued or assets are acquired or dedicated with respect to the funding thereof. All benefit plans or arrangements required to be set forth on Schedule 4.14 of the Sellers' Disclosure Schedule are referred to hereinafter collectively as the "Benefit Plans."

(b) Sellers have delivered, to the extent applicable, to Buyer accurate and complete copies of (i) the current plan documents for each Benefit Plan (or, with respect to any Benefit Plan that is unwritten, a detailed written description thereof); (ii) all current trust agreements or other funding instruments related to each Benefit Plan; (iii) all rulings, letters, and opinions regarding any Benefit Plan from the IRS, the U.S. Department of Labor ("DOL"), Pension Benefit Guaranty Corporation ("PBGC"), or any other governmental body that have been issued within the last three (3) years and any open requests therefor; (iv) all annual reports filed with any governmental body with respect to any Benefit Plan during the three (3) preceding years; (v) all current contracts with third-party service providers that relate to each Benefit Plan; (vi) all current summary plan descriptions, summaries of material modifications and memoranda, and any other material written communications pertaining to any Benefit Plan that has been distributed in the three (3) preceding years; and (vii) Sellers' HIPAA Notice of Privacy Practices.

(c) Except as provided on Schedule 4.14 of the Sellers' Disclosure Schedule:

(i) Neither Sellers nor any ERISA Affiliate has any material liability under Titles I or IV of ERISA in connection with any Benefit Plan for which Buyer has or could reasonably be expected to have any liability (other than liability for any regular contributions required under the terms of such Benefit Plans), contingent or otherwise, including, without limitation, liability with respect to any "multiemployer plan" (as defined in ERISA Sections 3(37)(A)), "multiple employer plan" (as described in Code Section 413(c)), or "single-employer plan" (as defined in ERISA Section 4001(a)(15)), whether or not terminated; self-insured or self-funded "multiple employer welfare arrangement" as such term is defined in ERISA Section 3(40); for any prohibited transactions (pursuant to Code Section 4975 or ERISA Section 406); excise tax or penalty; or breach of any fiduciary responsibilities.

(ii) Each Benefit Plan that is an "employee pension benefit plan" as defined in ERISA Section 3(2) and each related trust or annuity contract is and has been since its inception intended to be qualified and tax-exempt under the provisions of Code Sections 401(a) and 501(a), or, if applicable, Code Section 403(b), and, for each such Benefit Plan that is not stated on a master and prototype (M&P) and/or volume submitter plan on which reliance is and can be based on a favorable opinion or advisory letter without the adopting employer having requested an individual determination letter, has been determined by the IRS pursuant to an

individual favorable determination letter to be so qualified and tax-exempt or an application for such determination has been made and is currently pending; has not participated in any voluntary compliance or self-correction programs established by the IRS (or the DOL with respect to any fiduciary issues), or entered into a closing agreement with the IRS with respect to the form or operation of any Benefit Plan; is and has been since its inception in material compliance with its terms and, both as to form and in operation, with the requirements prescribed by any and all Laws that are applicable to such Benefit Plan, including, without limitation, ERISA and the Code; does not have any "unfunded accrued liability," as such term is defined under ERISA Section 3(30); has not experienced any "reportable events," as such term is defined under ERISA Section 4043; has not had any "accumulated funding deficiencies," as such term is defined under ERISA Section 302(a)(2) (prior to amendment by P.L. 109-280) or Code Sections 412(a) or 4971 (whether or not waived), nor for years after amendment by P.L. 109-280 any "funding shortfalls" as defined in Code Section 430(c); does not have any liabilities required to be disclosed on any annual report (Form 5500 series) that have not been disclosed; and has not been partially or fully terminated (through the cessation of contributions thereto or otherwise).

(iii) Each Benefit Plan that is not an "employee pension benefit plan" as defined in ERISA Section 3(2) is in material compliance with its terms and, both as to form and operation, with the requirements prescribed by any and all Laws that are applicable to such Benefit Plan, including, without limitation, ERISA and the Code; and such plan may be terminated at the time of Closing in accordance with its terms without any prior notice; no commitments have been made to provide lifetime or retiree benefits under any such plan; and no Persons have any vested rights under any such plan, other than the right to elect continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA").

(iv) Each Benefit Plan that is a "group health plan" (as defined in ERISA Section 607(1) or Code Section 5000(b)(1)) and that is maintained by Sellers or any ERISA Affiliate has been operated at all times in material compliance with ERISA, and to the extent applicable, the Code, the Social Security Act, and HIPAA.

(v) All contributions and payments with respect to all Benefit Plans required to be made in connection with any Benefit Plan have either been timely made or are reflected in the financial statements on an accrual basis. All returns, reports, and disclosure statements required to be made under applicable Law with respect to the Benefit Plans have been timely filed or delivered.

(vi) No Benefit Plan is currently or has been within the last three (3) years under audit, inquiry, or investigation by the IRS, DOL, or PBGC, and there are no outstanding issues with reference to the Benefit Plans pending before any governmental agency. Other than routine claims for benefits, there are no actions, mediations, audits, arbitrations, suits, claims, or investigations pending, or, to the Knowledge of Sellers, threatened, against or with respect to any of the Benefit Plans, and there are no threatened or pending claims by or on behalf of the Benefit Plans or by any employee of Sellers at the Facilities alleging a breach or breaches of fiduciary duties or violations of other applicable state or federal Law that could reasonably be expected to result in liability on the part of either Sellers or the Benefit Plans under any Law.

(vii) Sellers do not have any contracts, agreements, plans, or arrangements under which the contemplated transaction itself will result in any (i) payments becoming due from Sellers or any ERISA Affiliate to any current or former employee, director, or consultant, or (ii) accelerated vesting, payment, or increase in the amount of any benefit payable to or with respect to any such current or former employee, director, or consultant of Sellers or any ERISA Affiliate that could, in turn, reasonably be expected to result in any liability to Buyer.

(viii) There are no outstanding liabilities under the Retiree Medical Plan, nor will the continued operation of the Retiree Medical Plan in accordance with its terms result in any liability to Buyer following the Closing.

4.15 Litigation or Proceedings. Sellers have delivered to Buyer an accurate list and summary description (Schedule 4.15 of the Sellers' Disclosure Schedule) of all pending or, to the Knowledge of Sellers, threatened Proceedings with respect to the Facilities, the Purchased Assets, or Sellers or any Affiliate thereof (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or claim). All such Proceedings and 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 Sellers against covered Losses arising therefrom. Sellers are not in default under any order of any Governmental Entity wherever located. Except as set forth on Schedule 4.15 of the Sellers' Disclosure Schedule, there are no claims or Proceedings pending or, to the Knowledge of Sellers, threatened against Sellers or their Affiliates, the Facilities, or the Purchased Assets, at Law or in equity, or before or by any Governmental Entity wherever located.

4.16 Environmental Laws. Except as set forth on Schedule 4.16 of the Sellers' Disclosure Schedule, (i) to the Knowledge of Sellers, the Real Property is not subject to any material environmental hazards, risks, or liabilities, (ii) to the Knowledge of Sellers, Sellers are not in material violation of any Laws or orders pertaining to the protection of human health and safety or the environment (collectively, "Environmental Laws"), including, without limitation, the Comprehensive Environmental Response Compensation and Liability Act, as amended ("CERCLA"), and the Resource Conservation and Recovery Act, as amended ("RCRA"), and (iii) Sellers have received no written notice alleging or asserting either a violation of any Environmental Law or an obligation to investigate, assess, remove, or remediate any property, including but not limited to the Real Property, under or pursuant to any Environmental Law. Except as set forth on Schedule 4.16 of the Sellers' Disclosure Schedule, to the Knowledge of Sellers, no Hazardous Substances (which for purposes of this Section 4.16 shall mean and include polychlorinated biphenyls, asbestos, and any substances, materials, constituents, wastes, or other elements that are included under or regulated by any Environmental Law, including, without limitation, CERCLA and RCRA, but shall not include any chemicals, materials, or substances routinely used in cleaning and maintenance activities for the Real Property) have been, and through the Closing Date will be, disposed of on or released or discharged from or onto, or threatened to be released from or onto, the Real Property (including groundwater) by Sellers, or, to the Knowledge of Sellers, any third party, in violation of any applicable Environmental Law. Except as set forth on Schedule 4.16 of the Sellers' Disclosure Schedule, neither Sellers nor, to the Knowledge of Sellers, any prior owners,

operators, or occupants of the Real Property have allowed any Hazardous Substances to be discharged, processed, or otherwise released on the Real Property in a manner that is in violation of any Environmental Law, and Sellers have complied in all material respects with all Environmental Laws applicable to any part of the Real Property. The Facilities contain asbestos-containing material. Schedule 4.16 of the Sellers' Disclosure Schedule lists numerous reports, correspondence, operation and maintenance manuals, and other documents related to the asbestos-containing materials. These documents do not individually or collectively constitute a comprehensive asbestos survey of the Facilities or the Real Property. Without in any way limiting the generality of the foregoing, to the Knowledge of Sellers: (i) all current or former underground storage tanks located on the Real Property and information in Sellers' possession relating to the capacity, uses, dates of installation, and contents of such tanks located on the Real Property are identified in the environmental reports listed on Schedule 4.16 of the Sellers' Disclosure Schedule, (ii) there are not now, nor have there ever been, any collection dumps, pits, and disposal facilities or surface impoundments located on the Real Property for the containment of Hazardous Substances except as identified in Schedule 4.16 of the Sellers' Disclosure Schedule, and (iii) all existing underground storage tanks have been maintained in material compliance with all Environmental Laws. Except as set forth on Schedule 4.16 of the Sellers' Disclosure Schedule, Sellers hold all material environmental Permits required in connection with the use by Sellers of the Real Property or the operation of the Facilities and, to the extent permitted by Law, Sellers shall cause such environmental Permits to be transferred to Buyer (with Buyer's necessary cooperation and assistance), all of which are in good standing and are not subject to meritorious challenge.

4.17 Hill-Burton and Other Liens. Except as set forth on Schedule 4.17 of the Sellers' Disclosure Schedule, neither Sellers nor any of their predecessors have received any loans, grants, or loan guarantees pursuant to the Hill-Burton Act program, the Health Professions Educational Assistance Act, the Nurse Training Act, the National Health Planning and Resources Development Act, and the Community Mental Health Centers Act, as amended, or similar Laws or acts relating to health care facilities. The transactions contemplated hereby will not result in any obligation on Buyer or any of its Affiliates to repay any of such loans, grants, or loan guarantees, nor subject Buyer, its Affiliates, or the Purchased Assets to any Lien, including any requirement to provide uncompensated care.

4.18 Taxes.

(a) Sellers have filed on a timely basis, or validly extended the time for filing, all federal, state, and local tax returns required to be filed by it with respect to Taxes incurred relating to the Facilities (collectively, the "Tax Returns"). All Tax Returns are true and correct in all material respects and accurately reflect in all material respects the tax liabilities of Sellers. All amounts shown due on the Tax Returns have been or will be paid on a timely basis (including any interest or penalties and amounts due state unemployment authorities) to the appropriate tax authorities.

(b) Sellers have withheld in all material respects proper and accurate amounts from the compensation of its employees at the Facilities in compliance with all withholding and similar provisions of the Code, including employee withholding and social security Taxes, and any and all other applicable Laws, and have withheld, or caused to be

withheld, all Taxes on monies paid by them to independent contractors, creditors and other Persons for which withholding or payment is required by Law. All such amounts have been duly and validly remitted to the proper taxing authority.

(c) No deficiencies for any of Taxes relating to the Facilities or Purchased Assets have been asserted or, to the Knowledge of Sellers, threatened, and no audit on any Tax Returns is currently under way or, to the Knowledge of Sellers, threatened. There are no outstanding agreements by Sellers for the extension of time for the assessment of any Taxes. Sellers have not taken any action with respect to any Taxes that could reasonably be expected to have a material adverse impact upon the Facilities or the Purchased Assets as of or subsequent to Closing.

(d) Sellers have not received written notice of Tax Liens on any of the Purchased Assets and, to the Knowledge of Sellers, except for Permitted Liens, no such Tax Liens exist.

(e) No Governmental Authority has disputed in writing any Tax liability of Sellers. No claim has ever been made by a Governmental Entity in a jurisdiction where Sellers do not file Tax Returns that Sellers are or may be subject to Tax in that jurisdiction.

(f) No waiver of a statute of limitations with respect to 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 Sellers.

(g) Sellers are not a party to any Tax allocation or sharing Contract. Sellers are not and have not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(h) Each Seller and its subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the IRS.

(i) Neither Sellers nor any Affiliate of Sellers has any liability for the Taxes of any other Person (other than a subsidiary under IRS regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

4.19 Employee Relations.

(a) Except as set forth on Schedule 4.19 of the Sellers' Disclosure Schedule, all employees at the Facilities are employees of Sellers, and there has not been in the last three (3) years, there is not presently pending, and, to the Knowledge of Sellers, there is not presently threatened, (i) any strike, slowdown, picketing, work stoppage, or employee grievance process, or (ii) any Proceeding or claim against or affecting Sellers relating to an alleged violation of any Law pertaining to labor relations, including, without limitation, any charge, complaint, or unfair labor practices claim filed by an employee, union, or other Person with the National Labor Relations Board or any comparable Governmental Entity, organizational activity, or other labor dispute against or affecting Sellers, the Hospital, or their premises.

(b) With respect to the employees of Sellers at the Facilities: (i) no collective bargaining agreement exists or is currently being negotiated by Sellers; (ii) no application for certification of a collective bargaining agent is pending; (iii) no demand has been made upon Sellers for recognition by a labor organization; (iv) no union representation question exists; (v) no union organizing activities are, to the Knowledge of Sellers, taking place; and (vi) none of the employees of Sellers is represented by any labor union or organization.

(c) Except as set forth in Schedule 4.19 of the Sellers' Disclosure Schedule, Sellers have complied in all material respects with all Laws 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; Sellers are 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 Laws; there are no pending or, to the Knowledge of Sellers, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other entity), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other entity), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 4.19 of the Sellers' Disclosure Schedule states the number of employees terminated by Sellers within 90 days prior to the Closing Date, laid off by Sellers within the six (6) months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Sellers in the six (6) 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; (ii) the reason for termination, layoff, or reduction in work hours; and (iii) the location to which the employee was assigned. Except as set forth in Schedule 4.19 of the Sellers' Disclosure Schedule, Sellers have not violated the WARN Act or any similar state or local Law.

(e) To the Knowledge of Sellers, no officer, director, agent, employee, consultant, or independent contractor of Sellers 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 Sellers with respect to the Facilities; or (ii) to assign to Sellers or to any other Person any rights to any invention, improvement, or discovery. To the Knowledge of Sellers, no former or current employee of Sellers at the Facilities 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 business as heretofore carried on by Sellers at the Facilities.

(f) Sellers have 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 Sellers and their Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Sellers), 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 Sellers and their Affiliates working at the Facilities (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).

(g) All employees, former employees and independent contractors of Sellers have been 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 Law.

(h) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Sellers 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. No employee of Sellers who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Governmental Entity that must authorize such employment, and Sellers have complied with all applicable immigration laws and other Laws with respect to the employment of foreign nationals. Sellers have 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 the Knowledge of Sellers, threatened against Sellers relating to Sellers' compliance with federal immigration regulations, including compliance with federal immigration laws. Sellers have not received any letters 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 Sellers have not received any letters or other correspondence from the Department of Homeland Security or other Governmental Entities regarding the employment authorization of any employees of Sellers. If Sellers operate in a state or have a contract with a Governmental Entity that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, Sellers have been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as Sellers have been operating in such state or contracting with such Governmental Entity.

4.20 Supplies. The inventory and supplies constituting the Purchased Assets are substantially of a quality and quantity usable and salable in the ordinary course of business of the Facilities. Obsolete items or items below standard quality or in the process of repair have been written off the Financial Statements. Inventory and supplies are carried at cost, on a first-in, first-out basis, and are properly stated in the Financial Statements. The inventory levels are reasonable and justified based on past practices of Sellers at the Facilities.

4.21 Insurance. Schedule 4.21 of the Sellers' Disclosure Schedule contains an accurate schedule of the insurance policies or self-insurance funds maintained by Sellers covering the ownership and operations of the Facilities and the Purchased Assets, including the type of insurance, policy numbers, identity of insurers, limits, premiums, term and coverage. All of such policies are now, and until Closing will remain, valid and in full force and effect with no premium arrearage. Sellers have given in a timely manner to their insurers all notices

required to be given under their insurance policies with respect to all of the claims and actions covered by insurance, and no insurer has denied coverage of any such claims or actions. Sellers have not (a) received any notice or other communication from any such insurance company canceling, reducing or materially amending any of such insurance policies, and to the Knowledge of Sellers no such cancellation, reduction or amendment is threatened or justified or (b) failed to give any required notice or present any claim that is still outstanding under any of such policies with respect to the Facilities or any of the Purchased Assets. Since December 31, 2009, Sellers have not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. Except as set forth on Schedule 4.21 of the Sellers' Disclosure Schedule, Sellers have not made any claims against any excess insurance coverage set forth on Schedule 4.21 of the Sellers' Disclosure Schedule or any predecessor excess insurance policies.

4.22 Third Party Payor Cost Reports. Sellers have duly filed all required Cost Reports with respect to the Facilities for all the fiscal years through and including the fiscal year ended September 30, 2013. All of such Cost Reports accurately reflect the information required to be included thereon and such Cost Reports do not claim and neither the Facilities nor Sellers have received reimbursement in any amount in excess of the amounts provided by Law or any applicable agreement. All amounts shown as due from Sellers in the Cost Reports were remitted with such reports and all such amounts shown in the notices of program reimbursement as due have been paid. Schedule 4.22 of the Sellers' Disclosure Schedule indicates which of such Cost Reports have not been audited and finally settled and a brief description of any and all notices of program reimbursement, proposed or pending audit adjustments, disallowances, appeals of disallowances, and any and all other unresolved claims or disputes with respect to such Cost Reports; all Cost Reports not listed on Schedule 4.22 have been audited and notices of program reimbursement have been issued for all such other Cost Reports. Sellers have established adequate reserves with respect to the Facilities to cover any potential reimbursement obligations that may exist with respect to any such third party cost reports, and such reserves are set forth in the Financial Statements.

4.23 Medical Staff Matters. Sellers have provided to Buyer true, correct, and complete copies of the bylaws and rules and regulations of the medical staff of the Hospital, as well as a list of all current members of the medical staff. Sellers have 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 (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each medical staff member, (iii) the names of the medical staff members (current and former) with respect to whom Sellers have made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members with respect to whom any committee of the medical staff of the Hospital has recommended adverse action with respect to any member of the medical staff of the Hospital that is not yet final. Except as set forth in Schedule 4.23 of the Sellers' Disclosure Schedule, there are no adverse actions with respect to any medical staff members of the Hospital or any applicant thereto for which a medical staff member or applicant has requested a judicial review hearing that has not been scheduled or has been scheduled but has not been completed, and there are no pending or, to the Knowledge of Sellers, threatened disputes with applicants, staff members, or health professional affiliates, and Sellers know of no basis therefor, and all appeal periods with respect to any medical staff member or applicant against

whom an adverse action has been taken have expired. No member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

4.24 Quality and Condition of the Purchased Assets. The Purchased Assets and the Excluded Assets constitute all assets that are held or used by Sellers or any of their Affiliates and necessary for the conduct of the business and operation of the Facilities in the manner conducted as of the date of this Agreement. Except as set forth in Schedule 4.24 of the Sellers' Disclosure Schedule, all equipment and other material items of Personal Property and assets included in the Purchased Assets conform in all material respects to all applicable Laws relating to their use and operation by Sellers or their Affiliates with respect to the Facilities.

4.25 Intellectual Property; Computer Software. Schedule 4.25 of the Sellers' Disclosure Schedule lists all material trademarks, logos, trade secrets, service marks, trade names, patents, copyrights, inventions, processes, domain names and applications therefor (whether registered or common law) currently owned or legally used by Sellers with respect to the Facilities, free and clear of royalty and other payment obligations, claims of infringement or other Liens (collectively, the "Intellectual Property"). No proceedings have been instituted or are pending or, to the Knowledge of Sellers, threatened that challenge the validity of the ownership by Sellers of such Intellectual Property. Sellers have not licensed anyone to use such Intellectual Property and, to Sellers' Knowledge, there is no use or infringement of any such Intellectual Property by any other Person. Sellers own (or possess adequate and enforceable licenses or other rights to use) all material Intellectual Property and all material computer software programs and similar systems used in the conduct of their business.

4.26 Accounts Receivable. All Accounts Receivable constituting a part of the Purchased Assets represent and constitute bona fide indebtedness owing to Sellers with respect to the Facilities for services actually performed or for goods or supplies actually provided in the amounts indicated on the Financial Statements with no known set-offs, deductions, compromises, or reductions (other than reasonable allowances for bad debts and contractual allowances in an amount consistent with historical policies and procedures of Sellers with respect to the Facilities and that are taken into consideration in the preparation of the Financial Statements), and all such Accounts Receivable have been billed or are billable and are not subject to any Liens. Sellers have made available to Buyer a complete and accurate current aging report of all such Accounts Receivable.

4.27 Compliance Program. Sellers have provided to Buyer a copy of the Hospital's current compliance program materials, including without limitation, all program descriptions, compliance officer and committee descriptions, ethics and risk area policy materials, training and education materials, auditing and monitoring protocols, reporting mechanisms, and disciplinary policies. Except as set forth in a writing delivered by Sellers to Buyer or to the extent set forth on Schedule 4.27 of the Sellers' Disclosure Schedule, each Seller or Affiliate thereof (a) is not a party to a Corporate Integrity Agreement with the Office of Inspector General of the United States Department of Health and Human Services, (b) has no reporting obligations pursuant to any settlement agreement entered into with any Governmental Entity, (c) to the Knowledge of Sellers, has not been the subject of any government payer program investigation conducted by any federal or state enforcement agency within the past year, (d) has not been a defendant in any unsealed qui tam/False Claims Act litigation within the

past five (5) years, and (e) has not been served with or received, within the past year, any search warrant, subpoena, civil investigative demand, or contact letter by or from any federal or state enforcement agency (except in connection with medical services provided to third parties who may be defendants or the subject of investigation into conduct unrelated to the operation of the health care businesses conducted by Sellers at the Facilities). For purposes of this Agreement, the term "compliance program" refers to provider programs of the type described in the compliance guidance published by the Office of Inspector General of the Department of Health and Human Services.

4.28 Payments. To Sellers' Knowledge, none of the Facilities has made any request for payment from a Government Payment Program with respect to 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. To Sellers' Knowledge, Sellers have 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 Law. Neither Sellers nor any officer, director or trustee of Sellers 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 Sellers or their Affiliates have conducted, or are conducting, business. Schedule 4.28 of the Sellers' Disclosure Schedules sets forth a list of the ten largest non-governmental payors of the Facilities, determined on the basis of net patient revenues from services provided during the year ended September 30, 2013. Since September 30, 2013, no payor listed on Schedule 4.28 of the Sellers' Disclosure Schedule has terminated its contract with or materially reduced reimbursement rates to, or has notified Sellers in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Facilities.

4.29 Solvency. Sellers will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay their debts as they become due. Sellers have 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 Sellers' property and, to the Knowledge of Sellers, no other Person has filed or threatened to file such a petition against Sellers.

4.30 Transactions with Affiliates. Since December 31, 2012, Sellers have 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 Sellers or of any Affiliate of Sellers except upon terms that would have been paid or received by Sellers in similar transactions with independent parties negotiated at arm's length.

4.31 Partial Subsidiaries.

(a) Schedule 4.31 of the Sellers' Disclosure Schedule sets forth for each Partial Subsidiary (as defined herein): (i) its name and jurisdiction of incorporation or organization; (ii) the number of authorized shares of each class of its capital stock or other equity or non-equity interests; (iii) the number of issued and outstanding shares of each class of its

capital stock or other equity or non-equity interests, the names of the holders thereof, and the number of shares or other equity or non-equity interests held by each such holder; and (iv) the number of shares of its capital stock or other equity interests held in treasury.

(b) Each Partial Subsidiary: (i) if it is a for profit or nonprofit corporation, is duly incorporated, validly existing, and in good standing under the Laws of the state of its incorporation and is duly qualified and in good standing as a foreign corporation in the jurisdiction of its principal place of business if not incorporated therein; (ii) if it is a limited liability company, is duly organized, validly existing, and, if applicable, in good standing under the Laws of the state of its organization and is duly qualified and, if applicable, in good standing as a foreign limited liability company in the jurisdiction of its principal place of business if not organized therein; and (iii) if it is a partnership, trust, or other entity, is duly formed, validly existing, and, if applicable, in good standing in the jurisdiction of its principal place of business if not formed therein.

(c) Sellers have delivered to Buyer accurate and complete copies, as applicable, of the articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholder or membership agreement, as amended to date and in its possession, of each Partial Subsidiary. To the Knowledge of Sellers, none of the Partial Subsidiaries is in default under or in violation of any provision of its articles of incorporation, charter, bylaws, operating agreement, partnership agreement, or shareholders or membership agreement.

(d) Sellers have good, marketable, and indefeasible title to all shares of the stock or other equity or non-equity interests of the Partial Subsidiaries set forth in Schedule 4.31 of the Sellers' Disclosure Schedule and, except as set forth on Schedule 4.31 of the Sellers' Disclosure Schedule, have the absolute right to sell, assign, transfer, and deliver the same to Buyer, free and clear of all Liens. Other than Sellers, the Partial Subsidiaries, and those Persons set forth on Schedule 4.31 of the Sellers' Disclosure Schedules, there are no other Persons that own any interest in the Facilities or Purchased Assets. There are no Contracts with or rights of any Person to acquire, directly or indirectly, any material assets, or any interest therein, including any of the Purchased Assets, other than Contracts entered into in the ordinary course of the business of the Facilities or Contracts entered into with Tenet or Buyer with respect to the transactions contemplated by this Agreement.

(e) For purposes of this Agreement, the term "Partial Subsidiaries" means any and all corporations, partnerships, and limited liability companies in which Sellers or their Affiliates own or hold common stock, partnership interests, or membership interests amounting to less than 100% of the total outstanding common stock, partnership interests, or membership interests of such entity, and which common stock, partnership interests, or membership interests will be assigned by Sellers or their Affiliates to Buyer as part of the Purchased Assets.

4.32 Full Disclosure. To Sellers' Knowledge, the representations of Sellers in this Agreement and the Schedules do not contain any untrue statement of a material fact or 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. Sellers have provided or made

available to Buyer all material documents and information that have been requested by Buyer or its representatives.

ARTICLE V
REPRESENTATIONS AND WARRANTIES OF PARENT AND BUYER

As of the date hereof and as of the Closing Date, subject to such exceptions as are disclosed in the disclosure schedule supplied by Buyer to Sellers dated as of the date hereof ("Buyer Disclosure Schedule"), which Buyer Disclosure Schedule identifies the Section (or, if applicable, subsection) to which such exception relates (provided, however, that such disclosure shall also apply to particular matters represented or warranted in other Sections and subsections to the extent that it is readily apparent from the text of such disclosure) and which Buyer Disclosure Schedule is subject to updating between the date hereof and the Closing Date in accordance with the provisions of Section 13.1 hereof, Parent and Buyer, jointly and severally, represent and warrant to Sellers as follows:

5.1 Existence and Capacity. Each of Buyer and Parent is a limited liability company, duly organized and validly existing in good standing under the Laws of the State of Delaware. Each of Buyer and Parent has the requisite power and authority to enter into this Agreement, to perform its obligations hereunder, and to conduct its business as now being conducted.

5.2 Powers; Consents; Absence of Conflicts With Other Agreements, Etc. The execution, delivery, and performance by Buyer and Parent of this Agreement and all other agreements referenced herein, or ancillary hereto, to which Buyer or Parent is a party, and the consummation of the transactions contemplated herein by Buyer or Parent:

(a) are within its limited liability company powers, are not in contravention of the terms of its organizational documents, and have been duly authorized by all appropriate limited liability company action;

(b) except as provided in Schedule 5.2(b) of the Buyer Disclosure Schedule, do not require any approval or consent of, or filing with, any Governmental Entity bearing on the validity of this Agreement that is required by Law of any such Governmental Entity;

(c) will not conflict with, result in any breach or contravention of, or the creation of any Lien under any indenture or material Contract to which it is a party or by which it is bound; and

(d) will not violate any Law to which it or its assets may be subject.

5.3 Binding Agreement. This Agreement and all the other Transaction Documents to which Buyer or Parent is a party are and will constitute the valid and legally binding obligations of Buyer or Parent, respectively, and are and will be enforceable against Buyer or Parent, respectively, in accordance with the respective terms hereof and thereof, subject, to (a) applicable bankruptcy, reorganization, insolvency, moratorium, and other Laws

affecting creditors' rights generally from time to time in effect and (b) limitations on the enforcement of equitable remedies.

5.4 Litigation or Proceedings. There are no claims, actions, suits, proceedings, or investigations pending or, to the Knowledge of the Buyer, 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 or Parent to carry out the transactions contemplated by, or to perform their obligations under, this Agreement; or (d) would result in any change that would adversely affect in any material respect the ability of Buyer or Parent to perform any of their obligations hereunder in a timely manner.

5.5 Financing. Parent shall cause Buyer to have and to apply at the time of Closing, and Buyer shall have and apply at the time of Closing, sufficient cash or other immediately available funds necessary to enable Buyer to consummate the transactions contemplated hereby in accordance with the terms hereof.

ARTICLE VI
COVENANTS OF SELLERS PRIOR TO CLOSING

Between the date of this Agreement and the Closing:

6.1 Information. Sellers shall afford to the officers and authorized representatives and agents (which shall include accountants, attorneys, bankers, and other consultants) of Buyer full and complete access to and the right to inspect the plants, properties, books, and records of the Facilities, and will furnish Buyer with such additional financial and operating data and other information as to the business and properties of Sellers pertaining to the Facilities as Buyer may from time to time reasonably request without regard to where such information may be located. Buyer's right of access and inspection shall be exercised in such a manner as not to interfere unreasonably with the operations of the Facilities and the delivery of patient care. Buyer agrees that no inspections shall take place and no employees or other personnel of the Facilities shall be contacted by Buyer without Buyer's first providing reasonable notice to Sellers and coordinating such inspection or contact with Sellers. Michael Hammond shall be the designated representative of Sellers to be contacted in connection with all such information requests. Sellers shall notify Buyer of any material changes in the operations, financial condition or prospects of the Facilities and of any material complaints, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Facilities and shall keep Buyer reasonably informed of the status of such matters.

6.2 Operations. Sellers shall, with respect to the business or operation of the Facilities or otherwise regarding the Purchased Assets:

(a) carry on the business pertaining to the Facilities in substantially the same manner as presently conducted and not make any material change in personnel, operations, finance, accounting policies, or real or personal property pertaining to the Facilities;

(b) maintain the Purchased Assets and Facilities and all parts thereof in good operating condition, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Purchased Assets and Facilities, *provided* that Sellers shall consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) that exceed $250,000;

(c) perform all of their material obligations under Contracts relating to or affecting the Facilities or the Purchased Assets;

(d) keep in full force and effect present insurance policies or other comparable insurance pertaining to the Facilities and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(e) use their commercially reasonable efforts to maintain and preserve their business organizations intact, retain their present employees at the Facilities, and maintain their relationships with physicians, suppliers, customers, and others having business relations with the Facilities.

6.3 Negative Covenants. Sellers shall not, with respect to the business or operation of the Facilities or otherwise regarding the Purchased Assets, without the prior written consent of Buyer except as set forth in Schedule 6.3 of the Sellers' Disclosure Schedule:

(a) amend or terminate any of the Assumed Contracts, enter into any Contract, or incur or agree to incur any liability, except as provided herein or in the ordinary course of business;

(b) materially increase compensation payable or to become payable, make any bonus or severance payment to or otherwise enter into one or more bonus or severance Contracts with, or materially increase the benefits offered to, any employee at the Facilities, except increases in compensation, bonus payments or benefits or severance payments or benefits made in the ordinary course of business, consistent with past practices, and in accordance with existing personnel policies;

(c) create, assume, or permit to exist any new Lien (other than a Permitted Lien) upon any of the Purchased Assets, whether now owned or hereafter acquired, except in the ordinary course of business;

(d) acquire (whether by purchase or lease) or sell, assign, lease, or otherwise transfer or dispose of any property, plant, or equipment having a value in excess of One Hundred and Fifty Thousand Dollars ($150,000), except in the ordinary course of business;

(e) purchase capital assets other than in accordance with the approved capital budget of Sellers previously provided to Buyer;

(f) add, modify, or discontinue the provision of any material clinical service by the Facilities, 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;

(g) create, incur, assume, guarantee, or otherwise become liable for any liability or obligation or borrow any funds under existing credit lines or otherwise, except in the ordinary course of business consistent with historical practices;

(h) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations with respect to Accounts Receivable or other Purchased Assets, or agree to do any of the foregoing, except in the ordinary course of business of the Facilities and consistent with past practices;

(i) sell or factor any Accounts Receivable;

(j) change any accounting method, 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 changes in GAAP or applicable Laws;

(k) terminate, amend or otherwise modify in any material respect any employee benefit plan, except for amendments required to comply with this Agreement or applicable Law;

(l) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of Sellers, except as expressly contemplated by this Agreement;

(m) amend or agree to amend the governing documents of any Partial Subsidiary, except immaterial amendments or amendments required to comply with applicable Law or to assign and transfer to Buyer Sellers' investment in, or for Buyer to become a partner or member or shareholder of, such Partial Subsidiary; or

(n) take any action outside the ordinary course of business of the Facilities or their related ancillary services.

6.4 Governmental Approvals.

(a) Sellers shall (i) use their commercially reasonable efforts to obtain all Permits and any other approvals (or exemptions therefrom) from any Governmental Entity necessary or required to allow Sellers to perform their obligations under this Agreement (including, without limitation, approvals of the applications to the Connecticut Attorney General and Commissioner of Public Health of the State of Connecticut); and (ii) assist and cooperate with Buyer and its representatives and counsel in obtaining all Permits and other consents and approvals from any Governmental Entity that Buyer deems necessary or appropriate and in the preparation of any document or other material that may be required by any Governmental Entity as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Connecticut Attorney General and Commissioner of Public Health of the State of Connecticut).

(b) Sellers 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.

(c) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Law or practical necessity to enter into a Contract that supersedes or replaces an existing Contract between a Seller (or its Affiliate) and a third party. Such new Contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Sellers that are Excluded Liabilities. Alternatively, Buyer may be required by Law to assume, or may be deemed as a matter of Law to have assumed, obligations and liabilities of Sellers that are Excluded Liabilities. If Buyer enters into a replacement Contract or assumes such Excluded Liabilities, then – as between Sellers 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 Sellers (subject to the limitations set forth in Section 12.4), or otherwise diminish Sellers' obligations to Buyer or enlarge Sellers' liabilities to Buyer (or diminish Sellers' defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Sellers as a defense (whether of waiver, estoppel, consent, operation of Law, or otherwise) against Buyer's assertion of any claim under this Agreement against Sellers, 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.

6.5 FTC Notification. Sellers shall, if and to the extent required by Law, file all reports or other documents required or requested of them by the Federal Trade Commission ("FTC") or the United States Department of Justice ("Justice Department") under the HSR Act concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Sellers agree to furnish to Buyer such information concerning Sellers as Buyer needs to perform its obligations under Section 7.2 of this Agreement.

6.6 Additional Financial Information. Within five (5) Business Days after they are created (but in any event no later than fifteen (15) days following the end of each calendar month prior to Closing), Sellers shall deliver or cause to be delivered to Buyer true and complete copies of the unaudited balance sheets and the related unaudited statements of income (collectively, the "Interim Statements") of, or relating to, Sellers with respect to the Facilities for each month then ended, together with a year-to-date compilation and the notes, if any, related thereto, which presentation shall be true, correct, and complete in all material respects, shall have been prepared from and in accordance with the books and records of Sellers, and shall fairly present the financial position and results of operations of Sellers with respect to the Facilities as of the date and for the period indicated, all in accordance with GAAP consistently applied, except that such financial statements need not include required footnote disclosures. Sellers shall also deliver to Buyer, promptly after they are prepared, copies of any other financial or operating statements, reports, or analyses prepared by or for management relating to the Facilities or Purchased Assets.

6.7 Tail Insurance. Prior to the Closing, Sellers shall, at their sole cost and expense, obtain "tail" insurance to insure against professional and general liabilities of the Facilities (including any physicians employed by the Facilities) relating to all periods prior to the Closing. The insurance shall have coverage levels equal to the current policies insuring Sellers and shall be for a period of not less than five (5) years. The purchase by Sellers of any such "tail" insurance shall in no way affect the calculation of the Net Working Capital Amount for purposes of this Agreement.

6.8 Efforts to Close. Sellers shall use their commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Sellers shall notify Buyer as soon as practicable of any event or matter that comes to their attention that may reasonably be expected to prevent or materially delay the conditions to the obligations of Sellers being met.

6.9 Release of Liens. Sellers shall use all commercially reasonable efforts to cause all Liens on the Purchased Assets, other than the Permitted Liens, to be released and discharged at or before Closing.

6.10 Satisfaction of Bond Obligations. At its sole cost and expense, Sellers shall do all things necessary, desirable, and appropriate to cause the complete and valid payment or, if necessary, defeasance of its obligations under that certain Master Trust Indenture, Open End Mortgage and Security Agreement, dated as of May 1, 1997, by and between St. Mary's Hospital and Fleet National Bank, as Master Trustee (the "Master Trust Indenture"), which secures the Connecticut Health and Education Facilities Authority's Revenue Bonds, St. Mary's Hospital Issue, and Series E, such that all Liens secured by the Master Trust Indenture shall be released, in accordance with Section 13 of the Master Trust, at the time of the Closing.

6.11 No-Shop Clause. Until the first to occur of (i) termination of this Agreement or (ii) the Closing, Sellers shall not, and shall not permit any Affiliate of Sellers or any other Person acting for or on behalf of Sellers or any Affiliate of Sellers to, without the prior written consent of Buyer: (a) offer for sale, lease or other disposition all or substantially all of the Purchased Assets or any material portion thereof, or any ownership interest in any entity owning any of the Purchased 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 Sellers or any entity owning any of the Purchased Assets (collectively, a "Prohibited Transaction"), or negotiate with respect to an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Purchased Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Purchased 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 Purchased Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Purchased Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Sellers know or have reason to believe is in the process of considering a Prohibited Transaction. If Sellers, any Affiliate of Sellers, 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, Sellers will promptly advise such Person, by written notice, of this Section.

ARTICLE VII
COVENANTS OF BUYER PRIOR TO CLOSING

Between the date of this Agreement and the Closing:

7.1 Governmental Approvals. Buyer shall (i) use its commercially reasonable efforts to obtain all Permits and any other approvals (or exemptions therefrom) from any Governmental Entity necessary or required to allow Buyer to perform its obligations under this Agreement (including, without limitation, approvals of the applications to the Connecticut Attorney General and Commissioner of Public Health of the State of Connecticut), and (ii) assist and cooperate with Sellers and their representatives and counsel in obtaining all Permits and any other consents and approvals from any Governmental Entity that Sellers, in their reasonable discretion, deem necessary or appropriate and in the preparation of any document or other material that may be reasonably required by any Governmental Entity as a predicate to or as a result of the transactions contemplated herein (including, without limitation, approvals of the applications to the Connecticut Attorney General and Commissioner of Public Health of the State of Connecticut).

7.2 FTC Notification. Buyer shall, if and to the extent required by Law, file all reports or other documents required or requested of it by the FTC or the Justice Department under the HSR Act concerning the transactions contemplated hereby, and comply promptly with any requests by the FTC or Justice Department for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible after the execution and delivery of this Agreement. Buyer agrees to furnish to Sellers such information concerning Buyer as Sellers need to perform their obligations under Section 6.5 of this Agreement. Notwithstanding anything to the contrary contained in this Section 7.2 or in any other provision of this Agreement, in connection with the transactions contemplated by this Agreement, none of Parent, Buyer nor any of their Affiliates shall be required to (a) take or agree to take any action, including entering into any consent decree, hold separate order or other arrangement, that would require or result in the sale, divestiture or other direct or indirect disposition of the Purchased Assets or any assets or rights of Seller, Parent, Buyer or Tenet, or any of their respective Affiliates that is material to Buyer or any of its Affiliates or to the material benefits of the transaction for which Buyer has bargained for hereunder, or (b) limit Seller, Parent, Buyer or Tenet, or any of their respective Affiliates' freedom of action with respect to their ability to retain, conduct, consolidate or otherwise control the Purchased Assets or the assets of the Seller, Parent, Buyer or Tenet or their businesses that is material to Buyer or any of its Affiliates or to the material benefits of the transaction for which Buyer has bargained for hereunder.

7.3 Title Commitment. Buyer shall obtain, at its sole cost and expense, a current title commitment (the "Title Commitment") issued by a title company selected by Buyer (the "Title Company"), together with legible copies of all exceptions to title referenced therein. The Title Commitment shall set forth the state of title to the Real Property, together with all exceptions or conditions to such title, including, without limitation, all easements, restrictions, rights-of-way, covenants, reservations, and all other Liens affecting the Real Property that would appear in an owner's title policy, if issued. The Title Commitment shall contain the express commitment of the Title Company to issue an Owner's Title Policy (the "Title Policy")

to Buyer in an amount equal to the amount being allocated by the parties to the Real Property in accordance with Section 2.4, above, insuring good and marketable title to the Real Property with the standard printed exceptions endorsed or deleted as agreed by Buyer.

7.4 Surveys. Sellers shall deliver copies of all existing surveys of the Real Property to Buyer. Buyer shall obtain, at its sole cost and expense, current as-built surveys of the Real Property (the "Surveys"). The Surveys shall meet the requirements of an ALTA/ASCM survey and otherwise be in form and detail reasonably satisfactory to Buyer. Unless otherwise agreed by Buyer, the Surveys shall (i) be currently dated; (ii) show the location on the Real Property of all improvements, fences, evidences of abandoned fences, lakes, ponds, creeks, streams, rivers, easements, roads, and rights-of-way; (iii) identify all easements and rights-of-way by reference to the recording information applicable to the documents creating such easements or rights-of-way; (iv) show any encroachments onto the Real Property from any adjacent property, any encroachments from the Real Property onto adjacent property, and any encroachments into any easement or restricted area within the Real Property; (v) locate all existing improvements (such as buildings, power lines, fences, and the like); (vi) locate all dedicated public streets or other roadways providing access to the Real Property, including all curb cuts and all alleys; (vii) locate all set-back lines and similar restrictions covering the Real Property or any part thereof and any violations of such restrictions; and (viii) show thereon a legal description of the boundaries of the Real Property by metes and bounds or other appropriate legal description. Each Survey shall contain the surveyor's certification to the Buyer, Sellers, and the Title Company that (A) the Survey was made on the ground; (B) there are no visible or recorded easements, discrepancies, conflicts, encroachments, or overlapping of improvements except as shown on the Survey; (C) the Survey correctly shows all visible or recorded easements or rights of way across the Real Property or any other easements or rights of way of which the surveyor has been advised, including, without limitation, those matters affecting title reflected in the Title Commitment; (D) the Survey correctly shows the location of all buildings, structures, and other improvements situated on the Real Property; (E) the Survey conforms to all applicable minimum guidelines for surveys of comparable property as set forth in applicable Laws, regulations, or professional standards; (F) all streets abutting the Real Property and all means of ingress to and egress from the Real Property have been completed, dedicated, and accepted for public maintenance by the relevant municipal body; (G) except as shown thereon, the Real Property is not located within the 100 year flood plain or other flood hazard area; (H) the Survey is a true, complete, and accurate representation of the Real Property; and (I) such other matters as may be required by the Title Company to allow it to issue the Title Policy.

7.5 Efforts to Close. Buyer shall use commercially reasonable efforts to proceed toward the Closing and to satisfy the conditions to Closing, consistent with the other terms contained herein. Buyer shall notify Sellers as soon as practicable of any event or matter that comes to the attention of Buyer that may reasonably be expected to prevent or materially delay the conditions to the obligations of Buyer being met.

ARTICLE VIII
CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

Notwithstanding anything herein to the contrary, the obligations of Buyer to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Buyer at the Closing:

8.1 Representations/Warranties. The representations and warranties of Sellers contained in this Agreement shall be true in all material respects when made and, when read in light of the Sellers' Disclosure Schedule that has been updated in accordance with the provisions of Section 13.1 hereof, as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Sellers on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects. The Sellers' Disclosure Schedule, Exhibits and other instruments required under this Agreement have been updated or delivered by Sellers, and approved by Buyer, all in accordance with Section 13.1.

8.2 Pre-Closing Confirmations. Buyer shall have obtained documentation or other evidence satisfactory to Buyer in its reasonable discretion that Buyer has:

(a) Received satisfactory approval from all Governmental Entities whose approval is required to complete the transactions herein contemplated (including, without limitation, any and all certificate of need approvals by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Facilities to a for-profit entity by the Connecticut Attorney General) and all other material Permits of Governmental Entities required for Buyer to operate the Facilities after Closing, without the imposition of any condition that Buyer reasonably and in good faith deems materially burdensome to the operation of the Facilities after Closing;

(b) Received confirmation from all Governmental Entities, including licensure agencies, that, upon the Closing, either (i) all Permits required by Law to operate the Facilities as currently operated will be transferred to, or issued or reissued in the name of, Buyer, or (ii) Buyer will be permitted to operate the Facilities as currently operated from and after the Closing until such time as all appropriate Permits are issued or reissued in the name of Buyer;

(c) Obtained reasonable assurances that Government Payment Program certification of the Facilities for their operation by Buyer will be effective as of the Closing and that Buyer may participate in and receive reimbursement from such programs effective as of the Closing; and

(d) Reasonably assured itself that all waiting periods under the HSR Act have been terminated or expired and that any additional approvals required from the Justice Department and/or the FTC relating to the transactions contemplated herein have been obtained and are in form and substance satisfactory to Buyer in its reasonable discretion.

8.3 Actions/Proceedings. No Proceeding before any Governmental Entity (including the Connecticut Attorney General), unless resolved, shall have been instituted to restrain or prohibit the transactions herein contemplated, no Governmental Entity (including the Connecticut Attorney General) shall have taken any other action or made any request of any party hereto as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder and no Law shall be in effect restraining, enjoining or otherwise preventing the consummation of the transactions contemplated by this Agreement.

8.4 Adverse Change. Since the date hereof, there has not occurred and be continuing any Material Adverse Effect.

8.5 Consents to Assignments. All material consents, waivers, and estoppels of third parties that are reasonably necessary, in the opinion of Buyer, to complete effectively the transactions herein contemplated shall have been obtained and are in form and substance reasonably satisfactory to Buyer.

8.6 Vesting/Recordation. Sellers shall have furnished to Buyer, in form and substance satisfactory to Buyer, assignments or other instruments of transfer and consents and waivers by others, necessary or appropriate to transfer to and effectively vest in Buyer all right, title, and interest in and to the Purchased Assets, in proper statutory form for recording if such recording is necessary or appropriate.

8.7 Required Consents. Sellers shall have received consents to the assignment to Buyer of those certain Contracts and leases set forth on Schedules 1.08, 1.11 and 1.12 from the counterparties to such contracts and leases, which consents are in a form reasonably acceptable to Buyer (the "Required Consents").

8.8 Closing Documents. All Transaction Documents required by Section 3.2 shall have been delivered to Buyer.

8.9 Hill-Burton Facilities. No Lien affects any of the Purchased Assets or Facilities relating to or arising under the Hill-Burton Act.

8.10 Title Policy and Surveys. Buyer shall have received the Title Policy and all surveys required under Section 7.4.

8.11 Extraordinary Events. Sellers (a) are not in receivership or dissolution, (b) have not made any assignment for the benefit of creditors, (c) have not admitted in writing their inability to pay their debts as they mature, (d) have not been adjudicated bankrupt, (e) have 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 Law (and no such petition has been filed against them), and (f) have not entered into any Contract to do any of the foregoing on or after the Closing Date.

ARTICLE IX
CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLERS

Notwithstanding anything herein to the contrary, the obligations of Sellers to consummate the transactions described herein are subject to the fulfillment, on or prior to the Closing Date, of the following conditions precedent unless (but only to the extent) waived in writing by Sellers at the Closing:

9.1 Representations/Warranties. The representations and warranties of Parent and Buyer contained in this Agreement shall be true in all material respects when made and, when read in light of the Buyer Disclosure Schedules that have been updated in accordance with the provisions of Section 13.1 hereof, as of the Closing Date as though such representations and warranties had been made on and as of such Closing Date. Each and all of the terms, covenants, and conditions of this Agreement to be complied with or performed by Parent and Buyer on or before the Closing Date pursuant to the terms hereof shall have been duly complied with and performed in all material respects.

9.2 Governmental Matters. All material consents, authorizations, orders, and approvals of (or filings or registrations with) any Governmental Entity or other party required in connection with the execution, delivery, and performance of this Agreement shall have been obtained or made by Buyer when so required, except for any documents required to be filed, or consents, authorizations, orders, or approvals required to be issued, after the Closing Date.

9.3 Actions/Proceedings. No Proceeding before any Governmental Entity (including the Connecticut Attorney General), unless resolved, shall have been instituted to restrain or prohibit the transactions herein contemplated, no Governmental Entity (including the Connecticut Attorney General) shall have taken any other action or made any request of any party hereto as a result of which Sellers reasonably and in good faith deem it inadvisable to proceed with the transactions hereunder, and no Law shall be in effect restraining, enjoining or otherwise preventing the consummation of the transactions contemplated by this Agreement.

9.4 Insolvency. Buyer shall not (i) be in receivership or dissolution, (ii) have made any assignment for the benefit of creditors, (iii) have admitted in writing its inability to pay its debts as they mature, (iv) have been adjudicated a bankrupt, or (v) have 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 Law nor shall any such petition have been filed against Buyer.

9.5 Canonical Approvals. Sellers shall have received all canonical approvals necessary to enable it to consummate the transactions contemplated by this Agreement.

9.6 Employment Agreement. Buyer or its Affiliate shall have assumed the Amended and Restated Employment Agreement between SMH, Inc. and Chad Wable (the "CEO"), dated December 31, 2010.

9.7 Closing Documents. All Transaction Documents required by Section 3.3 shall have been delivered to Sellers.

ARTICLE X
COVENANT NOT TO COMPETE

Sellers hereby covenant that at all times from the Closing Date until the fifth (5th) anniversary of the Closing Date, Sellers and their Affiliates shall not, directly or indirectly, except as a consultant or contractor to or of Tenet or Buyer (or any Affiliate of Tenet or Buyer), (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 that offers services in competition with the Facilities, including but not limited to 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, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a 30-mile radius of the Hospital (the "Restricted Area"), without Buyer's prior written consent (which Buyer may withhold in its sole and absolute discretion); *provided*, however, that Sellers and their Affiliates will not be precluded from participating in activities that promote health care services for residents of the communities historically served by Sellers and their Affiliates through the Hospital, including the following activities: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening 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 competitive with services provided by Tenet and Buyer. In the event of a breach or threatened breach of this Article X, Sellers recognize that monetary damages shall be inadequate to compensate Buyer and its Affiliates and Buyer and its Affiliates shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach or threatened breach, with the costs (including reasonable attorneys' fees) of securing such injunction to be borne by Sellers. Nothing contained herein shall be construed as prohibiting Buyer or its Affiliates from pursuing any other remedy available to them for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Sellers and their Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Sellers further acknowledge and agree that the covenants and provisions of this Article X form part of the consideration under this Agreement and are among the inducements for Parent and Buyer to enter into and consummate 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 Sellers for agreeing to the restrictions contained in this Article X. 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.

ARTICLE XI
ADDITIONAL AGREEMENTS

11.1 Termination Prior to Closing.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) on or prior to the Closing Date by mutual consent of Sellers

and Buyer; (ii) by Buyer, by written notice to Sellers if any event occurs or condition exists which causes Sellers to be unable to satisfy one or more conditions to the obligation of Buyer to consummate the transactions contemplated by this Agreement as set forth in Article VIII; (iii) by Sellers, 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 obligation of Sellers to consummate the transactions contemplated by this Agreement as set forth in Article IX; and (iv) by Sellers or Buyer, if the Closing Date shall not have taken place on or before May 1, 2015 (which date may be extended by mutual agreement of Sellers and Buyer), provided, however, that the right to terminate this Agreement under this Section 11.1(a)(iv) shall not be available to either party if such party's failure to comply with or perform in any material respect any covenant or breach of any representation or warranty under this Agreement has been the cause of, or resulted in, the failure of the Closing to occur on or before such date.

(b) In the event that this Agreement is terminated by Buyer or Sellers (the "Terminating Party") because the other party (the "Breaching Party") refuses to close the transactions contemplated by this Agreement in violation of Section 11.20 when the Terminating Party is in compliance in all material respects with the terms of this Agreement, then the Breaching Party shall, within five (5) business days after receipt of written notice of such termination by the Terminating Party, pay to the Terminating Party by wire transfer of immediately available funds to an account designated by the Terminating Party a termination fee ("Termination Fee") equal to Four Million Five Hundred Thousand Dollars ($4,500,000).

(c) If this Agreement is validly terminated pursuant to this Section 11.1, 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 11.1(a), Sellers will remain liable to Buyer and Buyer will remain liable to Sellers for any breach of their respective obligations existing at the time of such termination (unless a party has paid the Termination Fee in accordance with Section 11.1(b), in which case such party and its Affiliates shall have no further liability to the other party as provided in Section 13.6(a)), 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 in accordance with the terms of this Agreement, and (ii) the expense allocation provisions of Section 13.10.

(d) The costs and expenses provisions of Section 13.10 and the confidentiality provisions of Section 13.11 shall remain in full force and effect and survive any termination of this Agreement.

(e) 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 11.1 shall survive any termination of this Agreement.

11.2 Post-Closing Access to Information. Sellers and Buyer acknowledge that subsequent to Closing each party may need access to the Records and other information or documents in the control or possession of the other party for the purposes of concluding the transactions herein contemplated, audits, compliance with governmental requirements and regulations, and the prosecution or defense of third party claims. Accordingly, Sellers, Buyer, agree that for a period of not less than five (5) years after Closing, each party will make reasonably available to the other party and their agents, independent auditors, counsel, and/or governmental agencies upon written request and at the expense of the requesting party such records, information and documents as may be available relating to the Purchased Assets for periods prior and subsequent to Closing to the extent necessary to facilitate concluding the transactions herein contemplated, audits, compliance with Law, and the prosecution or defense of claims.

11.3 Preservation and Access to Records After the Closing. After the Closing, Buyer shall, in the ordinary course of business and as required by Law, keep and preserve in their original form all medical and other Records of the Facilities that exist as of the Closing and constitute a part of the Purchased Assets delivered to Buyer at the Closing. Buyer acknowledges that as a result of entering into this Agreement and operating the Facilities it will gain access to patient and other information that is subject to state and federal Laws regarding confidentiality. Buyer agrees to abide by any such Laws relating to the confidential information it acquires. Buyer agrees to maintain the patient records delivered to Buyer at the Closing at the Facilities after Closing in accordance with applicable Law (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. §1395(v)(l)(i)), the privacy and security requirements of HIPAA, including, but not limited to, the Administrative Simplification subtitle of HIPAA, and applicable state requirements with respect to medical privacy and security and requirements of relevant insurance carriers. Upon reasonable notice, during normal business hours, at the sole cost and expense of Sellers and upon Buyer's receipt of appropriate consents and authorizations, Buyer will afford to the representatives of Sellers, including its counsel and accountants, full and complete access to, and copies of, the Records transferred to Buyer at the Closing (including, without limitation, access to patient records with respect to patients treated by Sellers at the Facilities). Upon reasonable notice, during normal business hours and at the sole cost and expense of Sellers, the Buyer shall also make its officers and employees available to Sellers at reasonable times and places after the Closing. In addition, Sellers shall be entitled, at Sellers' sole risk, to remove from the Facilities copies of any such patient records, but only for purposes of threatened or pending litigation (including any administrative proceeding or investigation) involving a patient to whom such records refer, as certified in writing prior to removal by counsel retained by Sellers in connection with such litigation and only upon Buyer's receipt of appropriate consents and authorizations. Any patient record so removed from the Facilities shall be promptly returned to Buyer following its use by Sellers. Any access to the Facilities, its records, or the Buyer's personnel granted to Sellers in this Agreement shall be upon the condition that any such access shall not materially interfere with the business operations of Sellers.

11.4 Certificate of Need 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 Entities shall have

granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

11.5 Tax and Medicare Effect. None of the parties (nor such parties' counsel or accountants) has made or is making any representations to any other party (nor such party's counsel or accountants) concerning any of the Tax or Medicare effects of the transactions provided for in this Agreement, as each party hereto represents that each has obtained, or may obtain, independent Tax and Medicare advice with respect thereto and upon which it, if so obtained, has solely relied.

11.6 Reproduction of Documents. This Agreement the Transaction Documents and all documents relating hereto, including, without limitation, (i) consents, waivers, and modifications that may hereafter be executed, (ii) the documents delivered at the Closing, and (iii) financial statements, certificates, and other information previously or hereafter furnished to Sellers or Buyer, may, subject to the provisions of Section 13.11 hereof, be reproduced by Sellers and Buyer by any photographic, photostatic, microfilm, micro-card, miniature photographic, or other similar process, and, if permitted by Law, Sellers and Buyer may destroy any original documents so reproduced. Sellers and Buyer agree and stipulate that any such reproduction 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 by Sellers or Buyer in the regular course of business) and that any enlargement, facsimile, or further reproduction of such reproduction shall likewise be admissible in evidence.

11.7 Cooperation on Tax Matters.

(a) Following the Closing, the parties shall cooperate fully with each other and shall make available to the other, as reasonably requested and at the expense of the requesting party, and to any taxing authority (to the extent required by Law), all information, records, or documents in their possession relating to the Purchased Assets, the Facilities, and the Assumed Liabilities as is reasonably necessary for the preparation and filing of any Tax Return, claim for refund of Taxes, or other filings relating to Taxes, or in connection with any audit or other Proceeding instituted by any taxing authority. In the case of any audit, examination, or other Proceeding with respect to Taxes for which Sellers are liable pursuant to this Agreement, Buyer shall promptly inform Sellers, and Buyer shall execute or cause to be executed powers of attorney or other documents necessary to enable Sellers to take all actions reasonably deemed necessary by Sellers with respect to such audit, examination, or Proceeding. Sellers shall have the right to control any such audit, examination, or proceeding, and, if there is a reasonable basis therefor, to initiate any claim for refund, file any amended return, or take any other action that they deem appropriate with respect to such Taxes.

(b) For Partial Subsidiaries treated as partnerships for federal income Tax purposes, the Tax years for the Partial Subsidiaries will close on the Closing Date with respect to Sellers and all applicable Tax Returns shall be prepared using a closing of the books method to the extent Buyer controls the preparation of the applicable Partial Subsidiary's tax returns. The closing of the Tax year with respect to Sellers and the applicable Tax Returns of the

Partial Subsidiaries shall be governed by Sections 706(c)(2)(A) and 708(b)(1)(B) of the Code, as applicable.

(c) Notwithstanding any other provision hereof to the contrary, Sellers and Buyer shall give prompt notice to the other party of any Tax Contest (as described in this section) with respect to (i) any Partial Subsidiary tax return for a Tax period that includes any date on or before the Closing Date or (ii) any other Tax assessment relating to the Purchased Assets and a Tax period (or portion thereof) prior to the Closing Date. Sellers shall have the right to control the conduct and resolution of such Tax Contest; provided, however, that, if any of the issues raised in such Tax Contest could have an impact on Taxes of Buyer, then Sellers shall afford Buyer the opportunity to control jointly the conduct and resolution of the portion of such Tax Contest which could have an impact on such Taxes; provided, further, that, if Sellers are not reasonably expected to indemnify Buyer pursuant to this Agreement for any liabilities arising from a Tax Contest and the resolution of the Tax Contest will not impact a Tax Return of Sellers, then Buyer shall exclusively control the conduct and resolution of such Tax Contest. If Sellers have the right to control the conduct and resolution of such Tax Contest but elect in writing not to do so within fifteen (15) days of receiving notice of such Tax Contest, then Buyer shall have the right to exclusively control the conduct and resolution of such Tax Contest, provided that Buyer shall keep Sellers informed of all developments on a timely basis and Buyer shall not resolve such Tax Contest in a manner that could reasonably be expected to have an adverse impact on the indemnification obligations of Sellers under this Agreement without Sellers' written consent. Each party shall bear its own costs for responding, participating in and defending such Tax Contest unless such cost is part of an indemnifiable claim pursuant to Article XII. For purposes of this Agreement, "Tax Contest" means any Tax inquiry, investigation, audit or other proceeding by any Governmental Entity responsible for the assessment or collection of Taxes.

(d) To the extent Buyer controls the preparation of the a Partial Subsidiary's tax returns, Buyer shall prepare or cause to be prepared and file or cause to be filed all Partial Subsidiary Tax Returns that are required to be filed after the Closing Date. Buyer shall permit Sellers to review and comment on each such Tax Return described in the preceding sentence prior to filing and shall make such revisions to such Tax Returns as are reasonably requested by Sellers.

11.8 Cost Reports. Sellers, at their expense, shall prepare and timely file all terminating and other Cost Reports required or permitted by Law to be filed for periods ending on or prior to the Closing Date ("Pre-Closing Cost Reports"), or as a result of the consummation of the transactions described herein. Buyer shall provide Sellers with reasonable access to all records and data necessary for completion of such Pre-Closing Cost Reports. Sellers shall work cooperatively with Buyer on any item reported on the Pre-Closing Cost Reports, including wage index and uncompensated care data, that might affect Buyer's reimbursement for cost reports filed by Buyer with respect to the Facilities. Buyer shall forward to Sellers any and all correspondence relating to Pre-Closing Cost Reports promptly after receipt by Buyer. The Buyer shall remit any funds, or forward any demands for payment, relating to Pre-Closing Cost Reports within ten (10) Business Days after receipt by Buyer. Sellers shall retain all rights to the Pre-Closing Cost Reports, including any amounts receivable or payable with respect to such reports or reserves relating to such Pre-Closing Cost Reports. Such rights shall include the right

to appeal any Medicare or Medicaid determinations relating to Pre-Closing Cost Reports. Sellers shall retain the originals of the Pre-Closing Cost Reports, correspondence, work papers and other documents relating to Pre-Closing Cost Reports; provided, however, that Sellers shall make certain that the Hospital retains copies of such Pre-Closing Cost Reports, correspondence, work papers and other documents in order that they are available to Buyer following the Closing Date. If Sellers decline to pursue any appeal with respect to any Seller Cost Reports that may have a financial impact on Buyer, Buyer shall have the right, but not the obligation, to pursue the appeal on behalf of Sellers, Sellers shall take all steps reasonably necessary to enable Buyer to pursue such appeal and Sellers shall be entitled to any recovery thereon which is attributable to the period prior to the Effective Time.

11.9 Misdirected Payments, Etc. Sellers and Buyer covenant and agree to remit, with reasonable promptness, to the other party any payments received, which payments are on or with respect to accounts or notes receivable owned by (or are otherwise payable to) the other. In addition, and without limitation, in the event of a determination by any Governmental Entity or third-party payor that payments to the Facilities resulted in an overpayment or other determination that funds previously paid by any program or plan to the Facilities must be repaid, Sellers shall be responsible for repayment of said monies (and/or defense of such actions) if such overpayment or other repayment determination was for services rendered prior to the Closing Date, and Buyer shall be responsible for repayment of said monies (and/or defense of such actions) if such overpayment or other repayment determination was for services rendered after the Closing Date. In the event that, following Closing, Buyer suffers any offsets against reimbursement under any third-party payor or Governmental Payment Programs due to Buyer relating to amounts owing under any such programs by Sellers or any of their Affiliates, Sellers shall immediately, upon written demand from Buyer, pay to Buyer the amounts so billed or offset.

11.10 Employee Matters; Medical Staff.

(a) As of the Closing Date, Sellers shall terminate all of their employees at the Facilities, and Buyer (or an Affiliate thereof) shall offer employment to all active employees in good standing as of the Closing Date (including those on leave (including without limitation, short-term disability, long-term disability, and worker's compensation) but not until such employees return from such leave) subject to the satisfactory completion by Buyer of Tenet's usual and customary hiring practices, including employee background checks and pre-employment screenings, in positions and at salaries at least equal to those then being provided by Sellers on the Closing Date and with employee benefits substantially similar to employee benefit plans offered to similarly-situated employees at other hospitals operated by subsidiaries of Tenet in similar markets. Offers of employment shall be made at least five (5) business days prior to the Closing Date. Nothing herein shall be deemed to create or grant to any such employees third party beneficiary rights or claims of any kind or nature. Buyer or its Affiliate shall credit all prior employees of Sellers and their Affiliates who are hired by Buyer or its Affiliate with years of service with Sellers and their Affiliates for all eligibility and vesting purposes (but not benefit accrual) under Buyer's employee benefit plans. In extending such benefits, Buyer or its Affiliate shall give such employees credit for the satisfaction of pre-existing condition limitations in its welfare benefit plans to the same extent that such employees have satisfied such limitations under the current welfare benefit plans of Sellers. Notwithstanding anything to the contrary

contained in this Section 11.10, Sellers acknowledge that all employment offers are for "at will" employment only, and neither Buyer nor any of its Affiliates shall have any obligation to continue to employ any employee at the Facilities unless provided otherwise herein. Medical staff members of the Hospital who are in good standing as of the Effective Time shall maintain medical staff privileges at the Hospital immediately after the Effective Time.

(b) Between the date of this Agreement and Closing, Buyer may run newspaper advertisements and use other solicitation methods (e.g., intranet or internet job boards) including those using the name of any of the Facilities, to recruit employees for the Facilities to commence on or after the Closing Date.

(c) Prior to Closing, Sellers will be responsible for compliance with the WARN Act and all similar state and local Laws with respect to the employees whose employment is at or related to the Facilities, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Sellers or their Affiliates on or prior to the Closing Date (except with respect to terminations of employment requested by Buyer), and after Closing, Buyer will be responsible for compliance by Buyer with the WARN Act and all similar state and local Laws with respect to the employees whose employment is at or related to the Facilities, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer or its Affiliates after the Closing Date

11.11 Uncompensated Care Policies. Buyer shall operate the Hospital in accordance with the "community benefit standards" set forth in Revenue Ruling 69-545, including, without limitation, the (i) acceptance of all patients enrolled in Government Payment Programs, (ii) acceptance of all emergency patients without regard to age, race, gender or ability to pay, (iii) maintenance of an open medical staff, (iv) provision of public health programs of educational benefit to the community, and (v) general promotion of public health, wellness, and welfare to the community through the provision of healthcare at a reasonable cost. Buyer shall cause the Hospital to treat any patient presented to the emergency room in accordance with the "community benefit standards" as described above and to cause the Facilities to remain eligible to participate in the Government Payment Programs. In addition, Buyer shall maintain charity and indigent care policies at least as favorable as those in effect at the Hospital at the time of Closing. The covenants set forth in this Section 11.11 shall be subject in all respects to changes in Law, policy, or regulation.

11.12 Use of Controlled Substance Permits. To the extent permitted by applicable Law, Buyer shall have the right, for a period not to exceed one hundred twenty (120) days following the Closing Date, to operate under the licenses and registrations of Sellers relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain its own such licenses and registrations. In furtherance thereof, Sellers shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in the form of Exhibit 4 hereto. Buyer shall apply for all such permits as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall also indemnify, defend and hold Sellers harmless from and against all claims, damages, losses, and other costs incurred, or required by Law to be paid, resulting in whole or in part from the use of such permits by Buyer following the Closing.

11.13 Maintenance of Catholic Identity. The Hospital's continuing operations from and after the Effective Time shall be conducted in conformity with the Ethical and Religious Directives for Catholic Health Care Services, as promulgated from time to time by the United States Conference of Catholic Bishops and as interpreted by the Archbishop of Hartford as they apply to the provision of health care services (the "Directives"). In addition, Buyer agrees:

(a) To continue to operate the Hospital as a Catholic health care facility in accordance with the moral, ethical, and social teachings of the Roman Catholic Church as expressed in the Directives as interpreted by the Archbishop of Hartford as they apply to the provision of health care services and to cause the Hospital to comply in all respects with and observe the Directives;

(b) To maintain an Ethics Committee with responsibility for the day-to-day monitoring of compliance with the Directives and other ethics-related matters, whose chairman shall be appointed, and whose members will be approved, by the Archbishop of Hartford, and whose responsibility would include reporting Directives compliance issues to the Archbishop at least annually or more frequently as appropriate;

(c) To have the Archbishop of Hartford appoint the Director of Pastoral Care whose duties include mission and values and who would be a member of the Senior Management Team of the Hospital;

(d) To have a Pastoral Care Department with staffing consistent with the size of the Hospital, the services of which will be made available to the Hospital's patients, their family members, health care professionals, and employees of all faiths and will be offered throughout the continuum of care provided by the Hospital;

(e) To ensure that the medical staff bylaws and employee codes of conduct and other hospital documents require adherence to the Directives;

(f) To provide annual education to the medical staff, the Directors, managers, and other appropriate personnel regarding adherence to the Directives;

(g) To maintain the Catholic names of the existing buildings and wings;

(h) To maintain at the Hospital the existing chapel or a chapel substantially similar thereto, that shall be maintained in at least its current condition, which shall be properly appointed and used for Catholic worship;

(i) To maintain a cross of at least ten (10) feet in height on the front exterior of the Hospital building; and

(j) To maintain appropriate signage, religious artifacts and statuary, and other symbols of Catholic identity at the Hospital, including but not limited to the name "Saint Mary's Hospital."

In the event that the Archbishop of Hartford withdraws recognition of the Hospital as a Catholic entity, then the name "Saint Mary's Hospital," the religious artifacts and statuary, and other symbols of Catholic identity, together with the right to use the Catholic names on the existing buildings and wings, shall be withdrawn and shall be transferred to the Archbishop of Hartford for utilization or disposition at such Catholic entities as he deems appropriate.

11.14 Continuing Operations of the Facilities. In addition, during all times that Buyer owns and operates the Hospital, Buyer agrees as follows with respect to the continuing operation of the Facilities following the Closing:

(a) To form and maintain a local health system advisory board for the Hospital (the "Local Health System Board"). The Local Health System Board will consist of the Archbishop of Hartford or his designee plus two (2) representatives of the Archbishop as designated from time-to-time by the Archbishop, all of whom shall be voting, ex officio members not subject to term limits, and nine (9) additional members, three (3) of whom shall be appointed by the Foundation, of whom two (2) shall be local physicians, and the remaining six (6) of whom shall be members appointed by the Buyer's Board of Directors. All nominees to the Local Health System Board shall be presented to, approved by, and at all times acceptable to the Archbishop. Except for the Archbishop (or his designee) and his two (2) representatives as noted above, each member shall serve for a maximum of three (3) consecutive three (3) year terms. In addition to the Archbishop or his designee and the Archbishop's two (2) representatives, the initial members of the Local Health System Board will include (i) the Hospital CEO, (ii) local community leaders selected from the Hospital's Board of Directors as of immediately prior to the Closing, and (iii) members of the Hospital's medical leadership. The Local Health System Board shall be responsible for the following responsibilities and such others as shall be assigned to it by Buyer:

(1) developing, and providing recommendations concerning, the Facilities' vision, mission and values statement; the Facilities' strategic plan; and operating and capital budgets for the Facilities;

(2) providing recommendations concerning the selection of, and providing periodic evaluations of, the Hospital's chief executive officer (with authority over the Facilities);

(3) monitoring operating performance of the Facilities;

(4) monitoring performance improvement initiatives at the Facilities;

(5) granting medical staff privileges and taking disciplinary action consistent with the medical staff bylaws;

(6) assuring the quality of medical care and medical staff compliance with applicable accreditation requirements;

(7) supporting physician recruitment efforts; and

(8) fostering community relationships and identifying service and education opportunities.

The Local Health System Board shall have the right to delegate the above responsibilities and certain other powers to other governing bodies and committees upon majority vote of the Local Health System Board.

The Local Health System Board shall have a standing committee known as the "Mission Integration Committee." The Committee shall be comprised of not less than three (3) members, and shall be responsible for oversight of the integration of mission and core values into the Hospital's activities, including the Hospital's services and benefits to the community and conformance to the Ethical and Religious Directives for Catholic Health Care Services. The Committee shall also be responsible for education of the members of the Local Health System Board about the Hospital's mission and values.

(b) During the five (5) year period following the Effective Time, the following actions shall require approval, by majority vote, of the Local Health System Board (i) merger, dissolution, consolidation, sale or other disposition of (A) the Hospital or (B) all or substantially all of Buyer's assets in Waterbury, Connecticut, unless, in either case, to an Affiliate of Buyer or to a buyer then currently operating similar facilities in the State of Connecticut; provided that this clause (i) shall not apply to (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital, or (z) any corporate-level transactions involving Tenet Healthcare Corporation's stock or securities, including macro-level mergers, recapitalizations or reorganizations; and (ii) Buyer ceasing operation of the Hospital as an acute care hospital with an emergency department. Thereafter, Buyer shall not take any of the actions described above without first consulting with the Local Health System Board. Furthermore, Buyer shall at all times consult with the Local Health System Board regarding (1) the development of, and changes to, the Hospital's strategic plan, (2) the Hospital's operating and capital budgets, and (3) the appointment and removal of the Hospital CEO.

(c) Use commercially reasonable efforts to cause the Hospital to continue to provide community benefit programs and services to improve access to health care services in its community and to improve the health status of the elderly, poor, immigrant, and other at-risk populations in such community, with such programs and services to include the provision of free care, mission and pastoral care programs, and community benefit programs consistent with the general levels of care as provided to these communities by Sellers prior to the Closing.

(d) To keep in place any portions, departments and/or wings of the Hospital that are referred to by the name or names of individuals or entities, including, without limitation, names of individuals who previously made donations to the Hospital or for whom dedications were otherwise made to honor certain individuals and to retain the names of such portions, departments and/or wings and to retain any plaques or other signs that may be located at the Hospital which evidence any such names and/or dedications, subject to Buyer's right to determine alternative ways to recognize donors if any such portions, departments and/or wings of

the Hospital that are referred to by the name or names of individuals or entities are materially reconfigured or eliminated; and

(e) To cause the Facilities to continue to participate in the Medicare and Medicaid programs.

(f) In the event of a sale of all of the Facilities for cash, whether by merger, sale, or other transaction, at any time prior to the third (3rd) anniversary of the Closing for a purchase price in excess of (a) the Purchase Price paid by Buyer hereunder (as adjusted pursuant to Article II hereunder), plus (b) the amount of any expenditures made by Tenet or its Affiliates with respect to the Facilities and their affiliated businesses in the Greater Waterbury region in such period, plus (c) any losses generated by the Facilities and its affiliated businesses in such period (such amount, the "Net Hospital Value"), then Parent and Buyer covenant and agree to convey to Seller or its designee immediately upon closing of such transaction by wire transfer of immediately available funds in an amount equal to twenty percent (20%) of the difference between (i) the Net Hospital Value, and (ii) the cash purchase price paid to Buyer and Parent in connection with such subsequent sale transaction. Notwithstanding anything to the contrary in this Section 11.14(g), this covenant shall not apply to (x) any sale required by a Governmental Entity, (y) any merger, sale or other transaction that does not relate solely or principally to the Facilities, or relates to a broader group of facilities or assets than the Facilities, or (z) any corporate-level transactions involving Tenet Healthcare Corporation's stock or securities, including macro-level mergers, recapitalizations or reorganizations.

11.15 Connecticut Transfer Act. The transaction contemplated herein involves real property or business operations that are or may be, in whole or part, "Establishments" within the meaning of the Transfer Act. Accordingly, for each of the Facilities that is or includes any such Establishment, Sellers and Buyer shall prepare an appropriate Transfer Act Form and accompanying ECAF to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Sellers shall sign the Form as the "Transferor," Buyer or its designee shall sign the Form as the "Certifying Party" and as the "Transferee." 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 Sellers); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). 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 Buyer incurs in connection with Transfer Act Activities. All undefined terms in this Section 11.15 shall have the meanings set forth in the Transfer Act.

11.16 <u>Capital Commitment.</u> After the Closing, Buyer agrees to spend 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) not less than Eighty-Five Million Dollars ($85,000,000) in the seven (7) years following the Effective Time on capital expenditures (including routine and non-routine capital expenditures and ongoing/deferred maintenance), including expansion or development of healthcare services, development of a comprehensive ambulatory network, creation of a physician platform, expansion and integration of clinical and information technology, quality improvement programs, expenditures for new equipment or equipment replacement, and the acquisition, development and improvement of hospital, ambulatory, medical office space, or other health care services in the greater Waterbury, Connecticut community. Notwithstanding the foregoing sentence, in the event that any legal requirement is enacted or imposed after Closing that (i) discriminates against, or adversely affects a disproportionate number of, for-profit hospitals or other for-profit health care entities, or (ii) causes Buyer to suffer a material decline in earnings before interest, taxes, depreciation and amortization on a consolidated basis, then, in either event, Buyer shall be relieved of its obligation to provide the above capital commitment

11.17 <u>Bulk Sales Law Compliance</u>. Buyer hereby waives compliance by Sellers with the requirements, if any, of Article 6 of the Uniform Commercial Code as in force in any state in which the Purchased Assets are located and all other similar Laws applicable to bulk sales and transfers.

11.18 <u>Right of First Opportunity for Sale of Hospital/Exit Process</u>.

(a) If, during the five (5)-year period immediately following Closing, (i) Buyer proposes to sell all or substantially all of the assets of the Hospital, or (ii) Parent proposes to directly sell or transfer its membership interest in Buyer to a Person that is not an Affiliate of Buyer (each, a "Hospital Sale"), neither Buyer nor Parent shall take any substantive action in furtherance of such Hospital Sale unless Buyer or Parent first provides the Foundation written notice (the "Hospital Sale Notice") of such proposed action. The Hospital Sale Notice shall include (A) a description of the proposed Hospital Sale, including the proposed price to be paid for the assets of the Hospital or Parent's membership interest in Buyer, (B) the structure of the proposed Hospital Sale and (C) proposed timeline of the transaction.

(b) The Foundation shall have a period of sixty (60) days from the date of the Hospital Sale Notice to submit an offer for the assets of the Hospital or membership interest in Buyer to Buyer or Parent, as applicable (either on its own behalf or on behalf of another third-party provided that such third party does not compete with Buyer or any Affiliate or subsidiary of Buyer). If either (i) the Foundation submits an offer on either its own behalf or on behalf of a third-party to Buyer or Parent, as applicable, and the parties fail to reach a definitive agreement pursuant to such offer within one hundred eighty (180) days from the date of the Hospital Sale Notice, or (ii) the sixty (60) day period expires without the Foundation submitting an offer to Buyer or Parent, as applicable, then Buyer or Parent, as applicable, shall be free to pursue and complete any sale of the assets or transfer of membership interest in Buyer with another Person; provided, however, that if a letter of intent or a definitive agreement between or among Buyer and/or Parent with another Person is not executed within a period of three hundred sixty five (365) days following the Hospital Sale Notice, then no Hospital Sale

may be completed unless Buyer or Parent, as applicable, delivers a new Hospital Sale Notice and complies again with the provisions of this Section 11.18.

(c) Notwithstanding anything to the contrary in this Section 11.18, this Section shall not apply to (x) any sale required by a Governmental Entity, (y) any merger, sale or other transaction that does not relate solely or principally to the Hospital, or relates to a broader group of facilities or assets than the Hospital, or (z) any corporate-level transactions involving Tenet Healthcare Corporation's stock or securities, including macro-level mergers, recapitalizations or reorganizations.

11.19 Casualty. If, on or before the Closing Date, any of the Facilities is destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of the Facilities in the aggregate is rendered unsuitable for its primary intended use for at least six (6) months, Buyer may elect, by giving written notice to Seller within fifteen (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 11.1(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 reasonable estimated cost to restore, repair or replace such Assets, in which event Sellers 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 Sellers shall pay, transfer and assign to Buyer at Closing the insurance proceeds (or the right to receive the insurance proceeds) payable on account of such destruction or damage, plus any deductibles or copayments required under the applicable insurance policy in respect of such claim. In the absence of an agreement among the parties regarding the amount of any Purchase Price reduction for purposes of clause (ii) above (if applicable), an MAI appraiser mutually selected by the parties and paid equally by Sellers and Buyer will determine any reduction in Purchase Price pursuant to such clause (ii).

11.20 Insurance Ratings. Sellers 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 Sellers and the Facilities for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so.

11.21 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 Transaction Document that such party is required by this Agreement to execute and deliver at Closing.

ARTICLE XII
SURVIVAL AND INDEMNIFICATION

12.1 Survival. All of the representations, warranties, covenants, and agreements made by the parties in this Agreement or pursuant hereto in any certificate, instrument, or document shall survive the consummation of the transactions in the manner described herein, and may be fully and completely relied upon by Sellers and Buyer, notwithstanding any investigation heretofore or hereafter made by any of them or on behalf of any of them, and shall not be deemed merged into any instruments or agreements delivered at the Closing or thereafter. Each party acknowledges that no representations or warranties are made except as specifically set forth herein or in any other Transaction Document. Notwithstanding anything in this Section 12.1 that may be to the contrary, any claim, demand, or cause of action with respect to a breach of any representation or warranty made in this Agreement must be made or brought, if at all, within eighteen (18) months after the Closing Date, other than (i) matters covered by Sections 4.1, 4.12 (with respect to title to the Real Property), 4.13 and 5.1, which shall survive for seven (7) years after the Closing Date, or matters covered by Sections 4.9, 4.10, 4.14, 4.16 and 4.18, which shall survive until the expiration of the applicable statute of limitations). For the avoidance of doubt, this Section 12.1 shall not affect any rights to bring claims after eighteen (18) months based on (a) any covenant or agreement of the parties that contemplates performance after the Closing, (b) the obligations of Sellers under Sections 12.2(ii), (iii) or (iv), (c) the obligations of Buyer under Section 12.3(ii), or (d) the obligations of the parties under Section 12.7.

12.2 Indemnification by Sellers. Subject to the limitations set forth in Section 12.4 hereof, Sellers shall defend and indemnify and hold Buyer's Indemnified Persons, and each of them, wholly harmless from and against any and all Losses that such Persons incur as a result of, or with respect to, (i) any inaccuracy, misrepresentation or breach of warranty by Sellers under this Agreement or in any Transaction Document to which Sellers are a party, (ii) any breach by Sellers of, or any failure by Sellers to perform, any covenant or agreement required to be performed by Sellers under this Agreement or any other Transaction Document, (iii) any of the Excluded Liabilities, (iv) any claim made by a third party with respect to the ownership of the Purchased Assets or the operation of the Facilities prior to the Effective Time, (v) any liabilities, costs or expenses incurred by Buyer or its Affiliates in connection with the Transfer Act Activities contemplated by Section 11.15, or (vi) any liabilities, costs or expenses incurred by Buyer or its Affiliates for asbestos abatement at any of the Facilities.

12.3 Indemnification by Buyer and Parent. Subject to the limitations set forth in Section 12.4 hereof, Buyer and Parent shall indemnify and hold Sellers' Indemnified Persons, and each of them, wholly harmless from and against any and all Losses that such Persons incur as a result of, or with respect to, (i) any inaccuracy, misrepresentation or breach of warranty by Buyer or Parent under this Agreement or in any Transaction Document to which Buyer or Parent is a party, (ii) any breach by Buyer or Parent of, or any failure by Buyer or Parent to perform, any covenant or agreement required to be performed by Buyer or Parent under this Agreement or any other Transaction Document, (iii) from and after the Effective Date, any Assumed Liabilities, or (iv) any claim made by a third party with respect to the ownership of the Purchased Assets or the operation of the Facilities following the Effective Time.

12.4 Limitations. Sellers, Buyer and Parent shall be liable under Section 12.2(i) or Section 12.3(i) (i.e., for inaccuracies, misrepresentations and breaches of warranties), as applicable, only when the total Losses claimed exceed Seven Hundred Fifty Thousand Dollars ($750,000), in the aggregate, after which Sellers or Buyer, as applicable, shall be liable to pay the entire amount of all Losses in excess of Seven Hundred Fifty Thousand Dollars ($750,000). The liability of (a) Buyer or Sellers for indemnification under Section 12.2(i) or Section 12.3(i), as applicable, shall be limited to an amount equal to Fifteen Million Dollars ($15,000,000), and (b) Sellers for indemnification under Section 12.2(vi) shall be limited to an amount equal to One Million Five Hundred Thousand Dollars ($1,500,000). Notwithstanding anything to the contrary, the limitations, including thresholds and ceilings, contained in this Section 12.4 shall not apply to any indemnification claims arising under Section 12.2 as a result of the intentional misrepresentation or fraud of Sellers.

12.5 Notice and Control of Litigation. If any claim or liability is asserted in writing by a third party against a party entitled to indemnification under this Article XII (the "Indemnified Party") that would give rise to a claim under this Article XII, the Indemnified Party shall notify the other party giving the indemnity (the "Indemnifying Party") in writing within fifteen (15) days of receipt of such written assertion of a claim or liability (with copies of all relevant written documentation, including papers served, if any. The Indemnifying Party shall have the right to defend a claim and control the defense, settlement, and prosecution of any litigation. If the Indemnifying Party, within ten (10) days after notice of such claim, fails to defend such claim, the Indemnified Party shall (upon further notice to the Indemnifying Party) have the right to undertake the defense, compromise, or settlement of such claim on behalf of and for the account and at the risk of the Indemnifying Party, subject to the right of the Indemnifying Party to assume the defense of such claim at any time prior to settlement, compromise, or final determination thereof. Anything in this Section 12.5 notwithstanding, (i) if there is a reasonable probability that a claim may materially and adversely affect the Indemnified Party other than as a result of money damages or other money payments, the Indemnified Party shall have the right, at its own cost and expense, to defend, compromise, and settle such claim, and (ii) the Indemnifying Party shall not, without the written consent of the Indemnified Party, settle or compromise any claim or consent to the entry of any judgment that does not include as an unconditional term thereof the giving by the claimant to the Indemnified Party of a release from all liability with respect to such claim. The foregoing rights and agreements shall be limited to the extent of any requirement of any third-party insurer or indemnitor. All parties agree to cooperate fully as necessary in the defense of such matters. Should the Indemnified Party fail to notify the Indemnifying Party in the time required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have resulted absent the Indemnified Party's failure to notify the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.6 Notice of Claim. If an Indemnified Party becomes aware of any breach of the representations or warranties of the Indemnifying Party hereunder or any other basis for indemnification under this Article XII (except as otherwise provided for under Section 12.5), the Indemnified Party shall notify the Indemnifying Party in writing of the same within forty-five (45) days after becoming aware of such breach or claim, specifying in detail the

circumstances and facts that give rise to a claim under this Article XII. Should the Indemnified Party fail to notify the Indemnifying Party within the time frame required above, the indemnity with respect to the subject matter of the required notice shall be limited to the damages that would have nonetheless resulted absent the Indemnified Party's failure to notify the Indemnifying Party in the time required above after taking into account such actions as could have been taken by the Indemnifying Party had it received timely notice from the Indemnified Party.

12.7 Mitigation of Damages. A party entitled to indemnification under this Article XII shall make commercially reasonable efforts to (i) mitigate its Losses or the amount of any indemnification claim it has or may have against the Person giving the indemnity and (ii) pursue claims under insurance policies relating to the facts and circumstances giving rise to the indemnification claim. For purposes of determining the amount of liability under this Article XII, appropriate reductions shall be made to reflect the amount actually recovered pursuant to any insurance policy or other third party recovery or collateral source that is received by the party entitled to indemnification with respect to the facts and circumstances giving rise to the indemnification claim less reasonable expenses incurred by an Indemnified Party in obtaining such recovery. If an indemnification payment is received by the party entitled to indemnification, and the party entitled to indemnification later receives insurance proceeds or other third party recoveries that were not previously credited against such indemnification payment when made, the party entitled to indemnification shall promptly, but in no event later than fifteen (15) days after the actual receipt of such insurance proceeds or other third party recoveries, pay to the party giving the indemnity a sum equal to the lesser of (x) such insurance proceeds and other third party recoveries and (y) the actual amount of the indemnification payment previously paid by the party giving the indemnity with respect to such indemnification claim.

12.8 Indemnity Reserve. Sellers agree to maintain an indemnity reserve in the amount of **$15,000,000** for a period of eighteen (18) months after the Closing so that Buyer will have meaningful financial recourse against Sellers for indemnification claims. Notwithstanding the foregoing, however, (a) if, as of the eighteen month anniversary of the Closing Date, one or more Buyer's Indemnified Persons has a pending indemnification claim, then the Sellers shall continue to maintain an indemnity reserve in the amount of such Buyer's Indemnified Persons' pending bona fide claim until the final resolution of all 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 11.15 that the Facilities have been remediated in full compliance with the Connecticut Remediation Standard Regulations, then Buyer and Sellers shall mutually agree upon a reasonable amount to remain in the indemnification reserve (in addition to any amount contemplated by subsection (a)) until such written approval has been received by Buyer. In connection with the foregoing, Buyer agrees that (i) any Licensed Environmental Professional or other remediation expert selected by Buyer for purposes of Section 11.15 and this Section shall be subject to the prior approval of Sellers, not to be unreasonably withheld or delayed, and (ii) Sellers shall have the right to audit any remediation costs and expenses incurred by Buyer to confirm that such costs and expenses are reasonably necessary in order for the Facilities to be in compliance with the Connecticut Remediation Standard Regulations.

ARTICLE XIII
MISCELLANEOUS

13.1 Schedules and Other Instruments. 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 the Closing Date, Sellers may update, supplement or amend the Sellers' Disclosure Schedule and Buyer may update, supplement and amend the Buyer Disclosure Schedule, in each case solely with respect to any matter occurring after the date of the last delivery of the relevant Disclosure Schedule, supplement or amendment thereto, as applicable, by delivery to the other party of such update, supplement or amendment and complying with the further provisions of this Section 13.1. After receiving any update, supplement or amendment pursuant to this Section 13.1, the party receiving such update, supplement or amendment (the "Receiving Party") shall have ten (10) Business Days to either accept such update, supplement or amendment or deliver a Deficiency Notice to the party providing such supplement, amendment or update (the "Delivering Party"); provided that if the Receiving Party does not deliver a notice to the Delivering Party specifying the deficiency of such update, supplement or amendment (a "Deficiency Notice") within such prescribed time period, the Receiving Party shall be deemed to have accepted such update, supplement or amendment to the applicable Disclosure Schedule. If a Deficiency Notice is sent, the parties shall use their commercially reasonable efforts to attempt to correct any such deficiency and agree on an appropriate update, supplement or amendment to the relevant Disclosure Schedule. If the parties have used their commercially reasonable efforts to correct any such deficiency and agree on an appropriate update, supplement or amendment to the relevant Disclosure Schedule but are unable to do so on or before the date that is ten (10) Business Days following receipt of such Deficiency Notice, then the Receiving Party may elect to terminate this Agreement upon notice to the Delivering Party delivered within five (5) Business Days after the expiration of the original ten (10) Business Day delivery period. Notwithstanding the foregoing, no update, supplement or amendment shall be delivered during the ten (10) Business Day period prior to the Closing Date unless agreed to by the Receiving Party.

13.2 Additional Assurances. The provisions of this Agreement shall be self-operative and shall not require further agreement by the parties except as may be herein specifically provided to the contrary; *provided*, however, at the request of a party, the other party or parties shall execute such additional instruments and take such additional actions as the requesting party may deem necessary to effectuate this Agreement. In addition and from time to time after Closing, Sellers shall execute and deliver such other instruments of conveyance and transfer, and take such other actions as Buyer reasonably may request, more effectively to convey and transfer full right, title, and interest to, vest in, and place Buyer in legal and actual possession of any and all of the Facilities and the Purchased Assets. Sellers shall also furnish Buyer with such information and documents in their possession or under their control, or which Sellers can execute or cause to be executed, as will enable the Buyer to prosecute any and all petitions, applications, claims, and demands relating to or constituting a part of the Facilities or the Purchased Assets. Additionally, Sellers shall cooperate and use their best efforts to have their present directors, officers, and employees cooperate with Buyer on and after Closing in furnishing information, evidence, testimony, and other assistance in connection with any action, proceeding, arrangement, or dispute of any nature with respect to matters pertaining to periods prior to Closing with respect to the items subject to this Agreement.

13.3 Consented Assignment. Notwithstanding anything to the contrary contained in this Agreement, if the sale, conveyance, assignment, transfer or delivery or attempted sale, conveyance, assignment, transfer or delivery to Buyer of any Purchased Asset would require any authorizations, approvals, consents or waivers from a Person other than Sellers or any Affiliate of Sellers and such authorizations, approvals, consents or waivers shall not have been obtained prior to the Closing Date or if the attempted assignment thereof would (i) constitute a breach of an Assumed Contract or Assumed Permit, (ii) render the Contract, claim or right void or voidable, or (iii) adversely affect the rights of Sellers thereunder so that Buyer would not receive in fact all such rights, subject to the conditions in Article VIII, the transactions contemplated hereby shall proceed, it being understood and agreed by the parties hereto that this Agreement shall not constitute a sale, conveyance, assignment, transfer or delivery of such Purchased Asset not authorized unless and until such authorization, approval, consent or waiver is obtained. After the Closing Date, Sellers shall continue to use commercially reasonable efforts to obtain any third party consents necessary to sell, convey, assign, transfer or deliver such Purchased Asset (but without payment of money by Sellers or Buyer), and Sellers shall cooperate with Buyer in any commercially reasonable arrangement designed to provide for Buyer the benefits of such Purchased Asset, including (x) performance by Sellers as agent if commercially reasonable to Sellers, and, in such case, Buyer shall be liable to Sellers in an amount equivalent to the amount that Buyer would be liable to the third party if the Purchased Asset had been assigned as of the Effective Time or (y) enforcement of any and all rights of Sellers against the other Person arising out of the breach or cancellation by such other Person or otherwise. Once authorization, approval or waiver of or consent for the sale, conveyance, assignment, transfer or delivery of any such Purchased Asset not sold, conveyed, assigned, transferred or delivered at the Closing is obtained, Sellers shall convey, assign, transfer and deliver such Purchased Asset to Buyer at no additional cost to the Buyer.

13.4 Consents, Approvals, and Discretion. Except as herein expressly provided to the contrary, whenever this Agreement requires any consent or approval to be given by a party, or whenever a party must or may exercise discretion, the parties agree that such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

13.5 Legal Fees and Costs. In the event a party elects to incur legal expenses to enforce or interpret any provision of this Agreement by judicial proceedings, the prevailing party shall be entitled to recover such legal expenses, including, without limitation, reasonable attorneys' fees, costs, and necessary disbursements at all court levels, in addition to any other relief to which such party shall be entitled.

13.6 Liquidated Damages.

(a) Each of the parties to this Agreement acknowledges that (i) the agreements contained in Section 11.1(b) are an integral part of the transactions contemplated by this Agreement; (ii) without these agreements, the parties would not enter into this Agreement; (iii) it would be extremely difficult and impracticable, if not impossible, to ascertain with any degree of certainty the amount of damages Sellers would suffer in the circumstances under which the Termination Fee is payable; and (iv) the Termination Fee is not a penalty but rather is liquidated damages in a reasonable amount negotiated as the parties' reasonable estimate of a

party's damages in the circumstances in which the Termination Fee is payable. Notwithstanding anything to the contrary in this Agreement, a party's right to receive payment of the Termination Fee pursuant to Section 11.1(b) shall be the sole and exclusive remedy of such party or any of its Affiliates against the other party, its Affiliates and their respective stockholders, partners or members 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 Section 11.1(b), none of the Breaching Party or its Affiliates or any of 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, except as provided under Sections 13.9, 13.10 or 13.11.

(b) If the Breaching Party fails to pay the Termination Fee pursuant to Section 11.1(b) when due and, in order to obtain such payment, the Terminating Party commences a suit or suits that result in a judgment or judgments against the Breaching Party for the Termination Fee, then the Breaching Party shall pay to the Terminating Party its costs and expenses (including attorneys' fees and expenses) in connection with such suit and the collection and enforcement of such judgment(s), together with interest on the amount of the Termination Fee from the date such payment was required to be paid until the date of payment in accordance with Section 13.30.

13.7 Choice of Law; Venue. The parties agree that this Agreement shall be governed by and construed in accordance with the Laws of the State of Connecticut without regard to conflict of Laws principles. Any dispute or proceeding arising out of or relating in any way to the subject matter of this Agreement shall be brought only in the United States District Court for the District of Connecticut or any Connecticut state court having appropriate jurisdiction over the matter.

13.8 Benefit/Assignment. Subject to 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. No party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, Buyer may designate an Affiliate to purchase any or all of the Purchased Assets and Facilities, subject to the obligations of Tenet under Section 13.26.

13.9 Brokerage Fees. Each party agrees to be solely liable for and obligated to satisfy and discharge all loss, cost, damage, or expense arising out of claims for fees or commissions of brokers employed or alleged to have been employed by such party.

13.10 Cost of Transaction. Except as otherwise provided in this Agreement, whether or not the transactions contemplated hereby shall be consummated, the parties agree as follows: (a) Sellers shall pay the fees, expenses, and disbursements of Sellers, their Affiliates, and their respective agents, representatives, accountants, and legal counsel incurred in connection with the subject matter hereof and any amendments hereto, including those fees, expenses and disbursements incurred in connection with the filing, by Sellers and their Affiliates, if any, under the HSR Act; (b) Buyer shall pay the fees, expenses, and disbursements of Buyer, its Affiliates, and its and their respective agents, representatives, accountants, and legal counsel incurred in connection with the subject matter hereof and any amendments hereto,

including those fees, expenses and disbursements incurred in connection with the filing, by Buyer and its Affiliates, if any, under the HSR Act: and (c) Sellers and Buyer shall share equally those fees, expenses and disbursements incurred in connection with obtaining approvals from the Commissioner of Public Health or the Connecticut Attorney General. Notwithstanding the foregoing, Buyer shall bear all costs of any conveyance or transfer taxes and the costs of the Surveys, Title Reports, Title Policies and any Phase I Environmental site assessment reports, Phase II or subsurface investigation reports and asbestos surveys.

13.11 Confidentiality. The Confidentiality Agreement entered into by the parties and dated October 4, 2012 shall remain in full force and effect during the term hereof and shall survive termination of this Agreement. It is understood by the parties hereto that the information, documents, and instruments delivered by a party to the other parties hereto are of a confidential and proprietary nature. The parties shall comply with and recognize all confidentiality and non-disclosure requirements that apply to the other party, specifically including the privacy requirements of the Administrative Simplification subtitle of HIPAA and state requirements and comply with all policies and safeguards relating to protected health information (as defined by federal regulations implementing HIPAA). Each of the parties hereto agrees that both prior and subsequent to the Closing it will maintain the confidentiality of all such confidential information, documents, or instruments delivered to it by each of the other parties hereto or their agents in connection with the negotiation of this Agreement or in compliance with the terms, conditions, and covenants hereof and will only disclose such information, documents, and instruments to its employees, members, directors, representatives, and agents (including consultants, attorneys, and accountants of each party) and applicable governmental authorities in connection with any required notification or application for approval or exemption therefrom. Each of the parties hereto further agrees that if the transactions contemplated hereby are not consummated, it will return all such documents and instruments and all copies thereof in its possession to the other parties to this Agreement or otherwise follow the procedures provided in the Confidentiality Agreement. Each of the parties hereto recognizes that any breach of this Section 13.11 would result in irreparable harm to the other parties to this Agreement and their Affiliates and that therefore any party to this Agreement shall be entitled to an injunction to prohibit any such breach or anticipated breach, without the necessity of posting a bond, cash, or otherwise, in addition to all of its other legal and equitable remedies. Nothing in this Section 13.11, however, shall prohibit the use of such confidential information, documents, or information for such governmental filings as in the opinion of a party's counsel are required by Law or governmental regulations or are otherwise required to be disclosed pursuant to applicable state Law.

13.12 Public Announcements. The parties collectively agree that no party hereto shall release, publish, or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior written consent of the other parties, except for information and filings reasonably necessary to be directed to governmental agencies to fully and lawfully effect the transactions herein contemplated or required in connection with securities and other Laws.

13.13 Communication with Governmental Entities Officials. Unless the parties hereto otherwise agree in writing after the execution of this Agreement, the parties will communicate jointly with Governmental Entities with respect to the transaction described

herein and will work together to develop a plan for coordinated communications by the parties. From the date of this Agreement until the earlier of (i) the Effective Time or (ii) the date that this Agreement is terminated in accordance with its terms, neither Buyer nor Sellers will, except as required by applicable Law, communicate separately with any Governmental Entities regarding the transaction described herein without prior approval of the other party. Notwithstanding the foregoing, Buyer and Sellers will be free, without prior approval of the other party, to communicate with Governmental Entities in the ordinary course and with respect to matters unrelated to the transaction described herein.

13.14 Waiver of Breach. 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. No failure to exercise nor any delay in exercising on the part of a party hereto any right, power or privilege hereunder or at law or in equity shall operate as a waiver thereof nor shall any single or partial exercise of any right, power or privilege preclude any other or further exercise thereof or the exercise of any other right, power or privilege. 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.

13.15 Notice. Any notice, demand, or communication required, permitted, or desired to be given hereunder shall be deemed effectively given when personally delivered, when received by receipted overnight delivery, or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

Sellers:	Saint Mary's Hospital System, Inc. 56 Franklin Street Waterbury, CT 06706 Attention: Chad Wable, President and CEO
With a simultaneous copy to:	Robert J. Anthony, Esq. Brown Rudnick LLP 185 Asylum Street, 38th Floor Hartford, CT 06103
Buyer or Parent:	Tenet Healthcare Corporation 1445 Ross Avenue, Suite 1400 Dallas, Texas 75202 Attention: Keith B. Pitts, Vice Chairman

With a simultaneous copy to:

Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
Attention: General Counsel

or to such other address, and to the attention of such other Person or officer, as any party may designate, with copies thereof to the respective counsel thereof as notified by such party.

13.16 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.

13.17 Gender and Number. Whenever the context of this Agreement requires, the gender of all words herein shall include the masculine, feminine, and neuter, and the number of all words herein shall include the singular and plural.

13.18 Divisions and Headings. The divisions of this Agreement into sections and subsections and the use of captions and headings in connection therewith are solely for convenience and shall have no legal effect in construing the provisions of this Agreement.

13.19 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 13.15 hereof, and promptly thereafter the parties will jointly appoint a mutually acceptable mediator to mediate the dispute. If the parties are unable to agree on a mutually acceptable mediator within thirty (30) days after receipt of notice of a dispute, 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.

(b) The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of thirty (30) days, unless a longer period is otherwise agreed.

13.20 Waiver of Jury Trial. EACH PARTY HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHTS IT MAY HAVE TO DEMAND THAT

ANY ACTION, PROCEEDING, OR COUNTERCLAIM ARISING OUT OF OR IN ANY WAY RELATED TO THIS AGREEMENT OR THE RELATIONSHIPS OF THE PARTIES HERETO BE TRIED BY JURY. THIS WAIVER EXTENDS TO ANY AND ALL RIGHTS TO DEMAND A TRIAL BY JURY ARISING FROM ANY SOURCE, INCLUDING, BUT NOT LIMITED TO, THE CONSTITUTION OF THE UNITED STATES OR ANY STATE THEREIN, COMMON LAW, OR ANY APPLICABLE STATUTE OR REGULATIONS. EACH PARTY HERETO ACKNOWLEDGES THAT IT IS KNOWINGLY AND VOLUNTARILY WAIVING ITS RIGHT TO DEMAND TRIAL BY JURY.

13.21 Accounting Date. The transactions contemplated hereby shall be effective for accounting purposes as of 12:01 a.m. on the day following the Closing Date, unless otherwise agreed in writing by Sellers and Buyer. The parties will use commercially reasonable efforts to cause the Closing to be effective as of a month end.

13.22 No Inferences. Inasmuch as this Agreement is the result of negotiations between sophisticated parties of equal bargaining power represented by counsel, no inference in favor of, or against, either party shall be drawn from the fact that any portion of this Agreement has been drafted by or on behalf of such party.

13.23 No Third Party Beneficiaries. The terms and provisions of this Agreement are intended solely for the benefit of Sellers and Buyer and their respective permitted successors or assigns, and it is not the intention of the parties to confer, and this Agreement shall not confer, third-party beneficiary rights upon any other Person.

13.24 Enforcement of Agreement. The parties hereto agree that irreparable damage would occur in the event that any of the provisions of this Agreement was not performed in accordance with its specific terms or was otherwise breached. It is accordingly agreed that the parties shall be entitled to an injunction or injunctions to prevent breaches of this Agreement and to enforce specifically the terms and provisions hereof in any court of competent jurisdiction, this being in addition to any other remedy to which they are entitled at law or in equity.

13.25 Entire Agreement/Amendment. This Agreement supersedes all previous contracts or understandings, including any offers, letters of intent, proposals, or letters of understanding, 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 other than those specified herein. As between or among the parties, no oral statements or prior written material not specifically incorporated herein shall be of any force and effect. The parties specifically acknowledge that in entering into and executing this Agreement, the parties rely solely upon the representations and agreements contained in this Agreement and no others. All prior representations or agreements, whether written or verbal, not expressly incorporated herein are superseded, and no changes in or additions to this Agreement shall be recognized unless and until made in writing and signed by all parties hereto. This Agreement may be executed in two (2) 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 may not be amended other than by written instrument signed by the parties hereto.

13.26 Tenet Guaranty. Tenet hereby unconditionally, irrevocably and absolutely guarantees to the Sellers the full and timely payment, performance and observation by Buyer and its Affiliates of each and every obligation, liability, covenant, and agreement of Buyer and its Affiliates arising out of, connected with, or related to this Agreement or any ancillary documents hereto and any extension, renewal, and/or modification thereof, including, without limitation: (i) the delivery of the Purchase Price and (ii) the satisfaction by Buyer of the indemnity obligations under this Agreement. The obligations of Tenet hereunder shall be primary and not secondary and it shall not be necessary for Sellers to exhaust their rights or remedies against Buyer or Parent or any other Person liable for the payment and performance of the obligations of Tenet hereunder. Tenet's liability under this Section 13.26 shall be construed as a payment guaranty and not a guaranty of collection. Tenet represents and warrants that this guaranty has been duly authorized and is the legal, binding and enforceable obligation of Tenet, enforceable in accordance with its terms, and that Tenet has obtained all necessary consents and approvals necessary to effectuate this guaranty simultaneously herewith. The guaranty obligations of Tenet under this Section 13.26 shall be continuing and shall remain in effect, subject to no offset or defense (other than the written consent or waiver by Sellers), and shall not be affected, modified, or impaired upon the happening from time to time of any of the following events, whether or not with notice or consent of Tenet:

(a) The compromise, settlement, release, change, modification, consolidation, or amendment (except to the extent of such compromise, settlement, release, change, modification, consolidation or amendment) of any or all of the obligations, duties, covenants, or agreements of any party under this Agreement or any ancillary documents hereto; or

(b) The extension of the time for performance of payment of money pursuant to this Agreement, or of the time for performance of any other obligations, covenants, or agreements under or arising out of this Agreement or any ancillary documents hereto or the extension or the renewal thereof.

Tenet waives any right to require the Sellers to file suit against Buyer or take any other action against Buyer as a prerequisite to the Sellers taking any action or bringing any suit against Tenet under this guaranty. Tenet, by agreeing to the performance of this guaranty, acknowledges and agrees that (i) it will benefit, directly or indirectly, from the Sellers and the Buyer's execution and delivery of this Agreement and related documents, and (ii) without Tenet's agreement to be bound by the provisions of this Section 13.26, the Sellers would not have agreed to enter into this Agreement or the related documents.

13.27 Other Owners of Purchased Assets. The parties acknowledge that certain of the Purchased Assets may be owned by Affiliates of Sellers and not Sellers. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Sellers agree that (i) its obligations with respect to any Purchased Assets shall be joint and several with any Affiliate that owns or controls such Purchased 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 Affiliates in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any Affiliate that owns or controls any Purchased Assets to meet all of Sellers' obligations under this Agreement with respect to such

Purchased Assets. Sellers hereby waive any defense to a claim made by Buyer under this Agreement based on the failure of any Person who owns or controls the Purchased Assets to be a party to this Agreement.

13.28 Risk of Loss. Notwithstanding any other provision hereof to the contrary, the risk of loss with respect to casualty to the Purchased Assets shall be borne by Sellers prior to the time of Closing and by Buyer from and after the Closing.

13.29 Transmission by Electronic Means. 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 Transaction Documents may be executed, and the signature pages thereto delivered, in like manner.

13.30 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 plus three percent (3%) *per annum*.

13.31 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 not a Business Day, 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 a Business Day.

[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.

SAINT MARY'S HEALTH SYSTEM, INC.

By: ______________________________

Name: ______________________________

Title: ______________________________

SAINT MARY'S HOSPITAL, INC.

By: ______________________________

Name: ______________________________

Title: ______________________________

VHS OF CONNECTICUT, LLC

By: ______________________________

Name: ______________________________

Title: ______________________________

VHS SAINT MARY'S HEALTH SYSTEM, LLC

By: ______________________________

Name: ______________________________

Title: ______________________________

TENET HEALTHCARE CORPORATION

By: ______________________________

Name: ______________________________

Title: ______________________________

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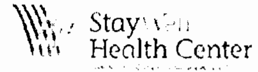
GREATER WATERBURY HEALTH IMPROVEMENT PARTNERSHIP



Community Health Needs Assessment

Final Summary Report

September 2013

HOLLERAN

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EXECUTIVE SUMMARY

The Greater Waterbury Health Improvement Partnership led a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in and around Waterbury, Connecticut beginning in 2012. The partnership consisted of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment examined a variety of indicators including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease).

The completion of the CHNA enabled the Greater Waterbury Health Improvement Partnership to take an in-depth look at its greater community. The findings from the assessment were utilized by the partnership to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The Greater Waterbury Health Improvement Partnership is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Statistical Data Profile of Waterbury, Connecticut and surrounding cities
- Household Telephone Survey with 1,100 community residents
- Focus Group Discussions with 24 health care providers and 33 community residents
- Key Informant Interviews with 205 community leaders and partners
- Prioritization Session
- Hospital Implementation Plans
- Community Health Improvement Plan (CHIP)

Prioritized Health Issues

Based on the feedback from community partners including health care providers, public health experts, health and human service agencies, and other community representatives, the Greater Waterbury Health Improvement Partnership plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Documentation

A final report of the CHNA was made public in September 2013 and can be found on the partner's websites. Hospital Implementation Plans, as well as a Community Health Improvement Plan (CHIP), were developed and adopted by each appropriate authority in September 2013.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Background

The Greater Waterbury Health Improvement Partnership is made up of a group of not-for-profit organizations serving the residents of Waterbury, Connecticut and surrounding communities. The Greater Waterbury Health Improvement Partnership defined their current service area as the City of Waterbury and the surrounding communities served by Saint Mary's Hospital and Waterbury Hospital. The area encompasses southwest Connecticut and is relatively large with a population of approximately 313,000 residents. The geographic area was defined by primary service area (PSA) and secondary service area (SSA). The PSA is the area that the partnership predominantly serves and the hospitals main catchment area. It comprises all of Waterbury and has a population of approximately 110,000 residents. The SSA includes portions of the surrounding communities served by the two hospitals and has a population of approximately 203,000 residents. The conclusions drawn from the various research components focus on the primary service area, the town of Waterbury, Connecticut.

CHNA Partners

- The City of Waterbury
- Connecticut Community Foundation
- Saint Mary's Hospital
- StayWell Health Center
- Waterbury Department of Public Health
- Waterbury Hospital
- The United Way

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

Quantitative Data:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates and other health statistics for Waterbury, Connecticut and surrounding cities was compiled.

- A Household Telephone Survey was conducted with 1,100 randomly-selected community residents. The survey was modeled after the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) which assesses health

status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

Qualitative Data:

- Six Focus Groups were held with 24 health care providers and 33 community residents in February 2013.

- Key Informant Interviews were conducted with 205 community leaders and partners between February and April 2013.

Research Partner

The Greater Waterbury Health Improvement Partnership contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from the household telephone survey
- Conducted focus groups with community members
- Conducted key informant interviews with community leaders and partners
- Facilitated a Prioritization and Planning Session
- Prepared all reports

Community Representation

Community engagement and feedback were an integral part of the CHNA process. The Greater Waterbury Health Improvement Partnership sought community input through focus groups with health care providers and community members, key informant interviews with community leaders and partners, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

It should be noted that the availability and time lag of secondary data may present some research limitations. Additionally, language barriers, timeline, and other restrictions may have impacted the ability to survey all community stakeholders. The Greater Waterbury Health Improvement Partnership sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, the Greater Waterbury Health Improvement Partnership prioritized community health issues and developed an implementation plan to address prioritized community needs.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in the Greater Waterbury Health Improvement Partnership service area.

Secondary data was collected from reputable sources including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), Waterbury Department of Health, and the Connecticut Department of Public Health. Data sources are listed throughout the report and a full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness & Communicable Disease Statistics
- Mental Health Statistics
- Cancer Statistics
- Environmental Health Statistics
- Health Care Access Statistics
- Crime Statistics

Secondary Data Profile Key Findings

This section serves as a summary of the key takeaways from the secondary data profile. A full report of the findings is available through the Greater Waterbury Health Improvement Partnership.

Demographic Statistics

According to U.S. Census Bureau estimates (2009-2011), the total population in Waterbury, Connecticut is 110,075, a decline of 2.55% since 2000. The majority of residents identify as White (58.2%), indicating a less diverse population when compared to peer cities, but a more diverse population when compared to all of Connecticut. Approximately 19% of residents identify as Black/African American and 30.1% identify as Hispanic or Latino. The primary spoken language is English, but 31.6% of residents speak a language other than English at home. The median age in Waterbury is 35.2, which denotes a younger population when compared to Connecticut, but an older population when compared to most peer cities (U.S. Census Bureau, 2012).

Table 1. Overall Population (2009-2012)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
White	78.6%	58.2%	32.2%	46.7%	48.6%	59.6%
Black/African American	9.8%	19.4%	37.2%	34.4%	34.5%	14.8%
Asian	3.8%	1.7%	2.5%	4.9%	3.6%	8.05%
Two or more races	2.3%	5.6%	4.0%	2.9%	1.9%	1.7%
Hispanic or Latino (of any race)[b]	13.0%	30.1%	42.4%	26.3%	36.7%	24.4%

Source: U.S. Census Bureau, 2012

[a] Percentages may equal more than 100% as individuals may report more than one race

[b] Hispanic/Latino residents can be of any race, for example, White Hispanic

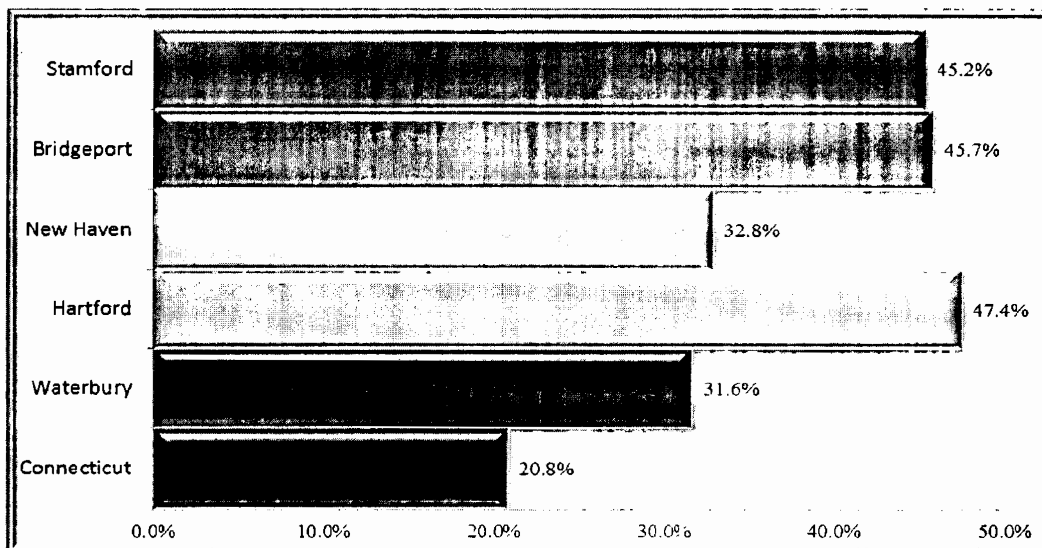

Figure 1. Percentage of population speaking a language other than English, 2009-2011
Source: U.S. Census Bureau, 2012

Waterbury is comprised primarily of family households (63.2%), which are defined as more than one person living together, either as relations or as a married couple. These households and nonfamily households are less likely to live in owner-occupied units (49.6%) compared to Connecticut (68.9%), but more likely to live in owner-occupied units compared to most peer cities. The median value for owner-occupied units is $164,000, which is lower than the median value across the state ($293,100) and all peer cities (U.S. Census Bureau, 2012).

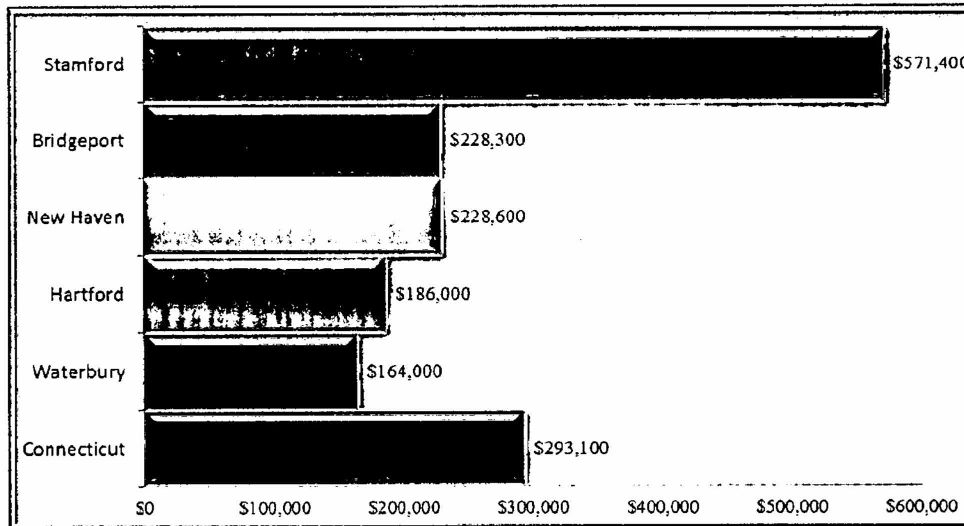

Figure 2. Median value for owner-occupied unit, 2009-2011
Source: U.S. Census Bureau, 2012

Approximately 40% of Waterbury residents aged 15 years and over have never been married. This is greater than the percentage across Connecticut (31.8%), but lower than the percentage across most peer cities. Among those residents who have been married, a higher percentage are divorced (11.6%) compared to Connecticut (10.2%) and all peer cities (U.S. Census Bureau, 2012).

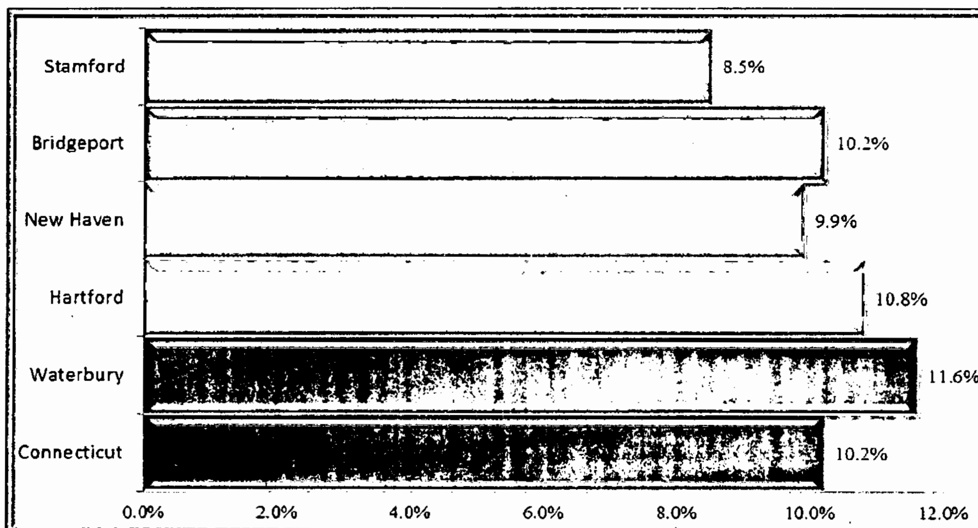

Figure 3. Divorce Rate, 2009-2011
Source: U.S. Census Bureau, 2012

The median income for households and families across Waterbury ($41,499 and $49,059 respectively) is lower than across all of Connecticut ($69,243; $86,395). However, it is higher when compared to most peer cities. The same trend is true of the median income for workers. The percentage of families and individuals living in poverty in the past 12 months is higher in Waterbury than in all of Connecticut (U.S. Census Bureau, 2012). More residents in Waterbury are also enrolled in social assistance programs like Temporary Family Assistance and Medicaid when compared to Connecticut and most peer cities. Between the years 2011 and 2012, 28.2% of residents were enrolled in Temporary Family Assistance and 38.1% were enrolled in Medicaid. Medicaid enrollment has been on the rise across all of Connecticut and its cities since 2006 (Connecticut Department of Social Services, n.d.).

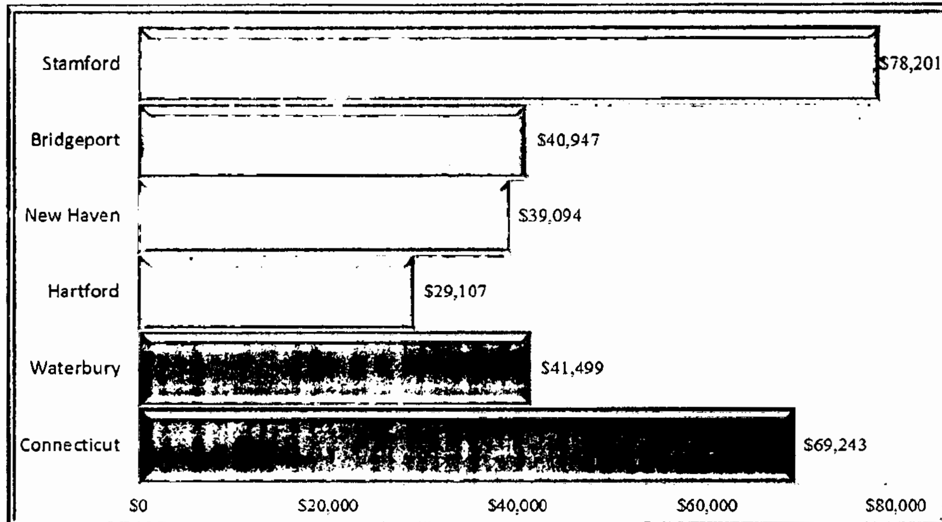

Figure 4. Median household income, 2009-2011
Source: U.S. Census Bureau, 2012

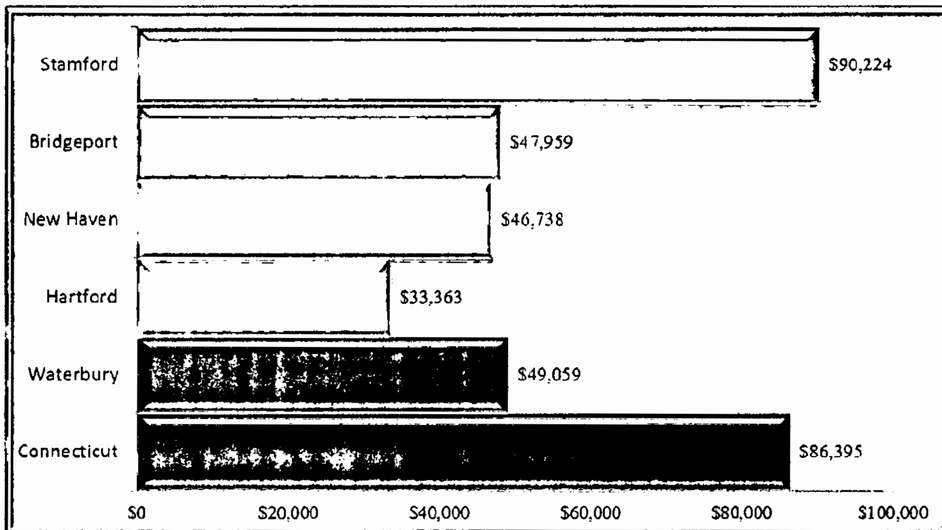

Figure 5. Median family income, 2009-2011
Source: U.S. Census Bureau, 2012

Table 2. Poverty Status of Families and People in the Past 12 Months (2010)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Families	6.7%	17.1%	29.9%	20.8%	18.0%	7.5%
With related children < 18 years	10.8%	26.3%	39.3%	30.0%	25.3%	11.6%
With related children < 5 years	12.5%	22.4%	46.1%	21.3%	20.6%	12.7%
Married couple families	2.3%	5.6%	9.3%	7.4%	7.3%	3.4%
With related children < 18 years	3.1%	7.7%	12.1%	11.2%	10.7%	4.5%
With related children < 5 years	3.4%	7.5%	11.3%	9.2%	6.0%	3.8%
Families with female householder, no husband present	22.9%	35.5%	44.5%	36.9%	34.1%	22.1%
With related children < 18 years	30.8%	44.3%	51.6%	44.9%	40.8%	30.4%
With related children < 18 years	40.1%	47.7%	60.8%	42.7%	41.1%	35.8%
All people	9.5%	20.6%	32.9%	26.3%	21.9%	11.0%

Source: U.S. Census Bureau, ACS estimates

According to the U.S. Census Bureau (2012), the unemployment rate in Waterbury is 12.7%. This rate is higher than the unemployment rate across Connecticut (8.5%). It is favorable or comparable to peer cities. Of the residents who are employed, the majority work in management, business, science, and arts and are private wage and salary workers. A notable percentage of residents are also employed in a service occupation.

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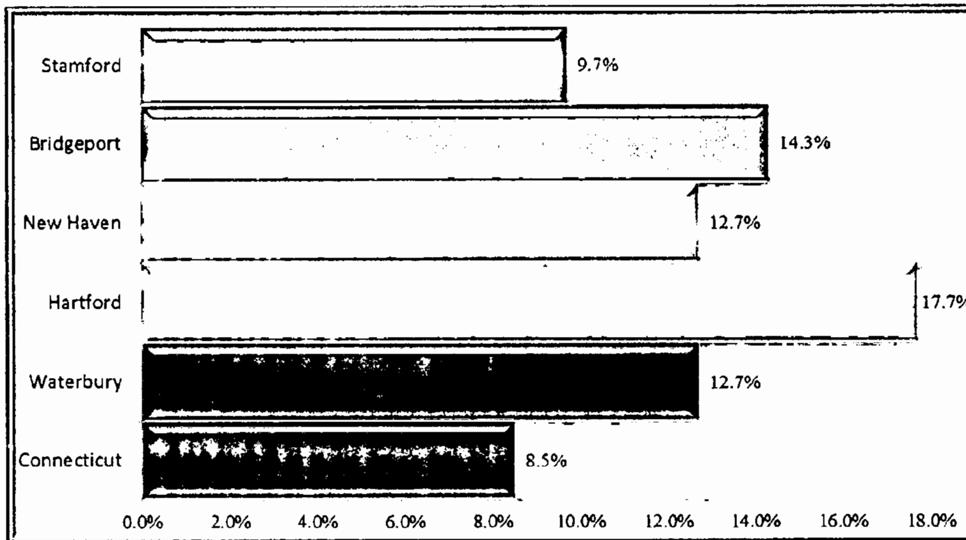


Figure 6. Unemployment rate for civilian labor force, 2009-2011
Source: U.S. Census Bureau, 2012

Education is an important social determinant of health. Studies have shown that individuals who are less educated tend to have poorer health outcomes. High school and higher education graduation rates are lower in Waterbury (78.7% and 17.2% respectively) than in Connecticut (88.6% and 35.7% respectively) and comparable to peer cities (U.S. Census Bureau, 2012).

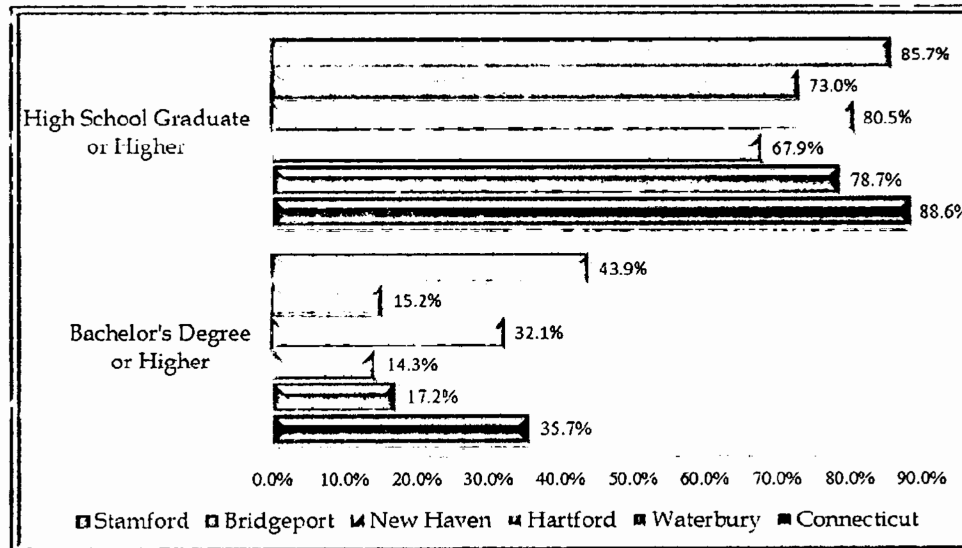


Figure 7. Educational attainment, 2009-2011
Source: U.S. Census Bureau, 2012

Health Status Indicators

Mortality Rates

The overall crude mortality rate for Waterbury, Connecticut is 9.2 per 1,000. This is higher than the mortality rate for Connecticut (8.1 per 1,000) and peer cities. A contributing factor to the higher overall mortality rate in Waterbury compared to peer cities may be its slightly older population. However, this does not apply when comparing to all of Connecticut as the state has a higher median age (Connecticut Department of Public Health, 2011).

The graphs below detail the age-adjust deaths rates per 100,000 for three of the leading causes of death in Waterbury. For all causes, Waterbury has a higher death rate than Connecticut. For chronic lower respiratory disease, Waterbury has a higher death rate (37.2) than Connecticut and all peer cities. Death rates due to heart disease and cancer in Waterbury are comparable to peer cities, but are still of concern as the top two leading causes of death (Connecticut Department of Public Health, 2011).

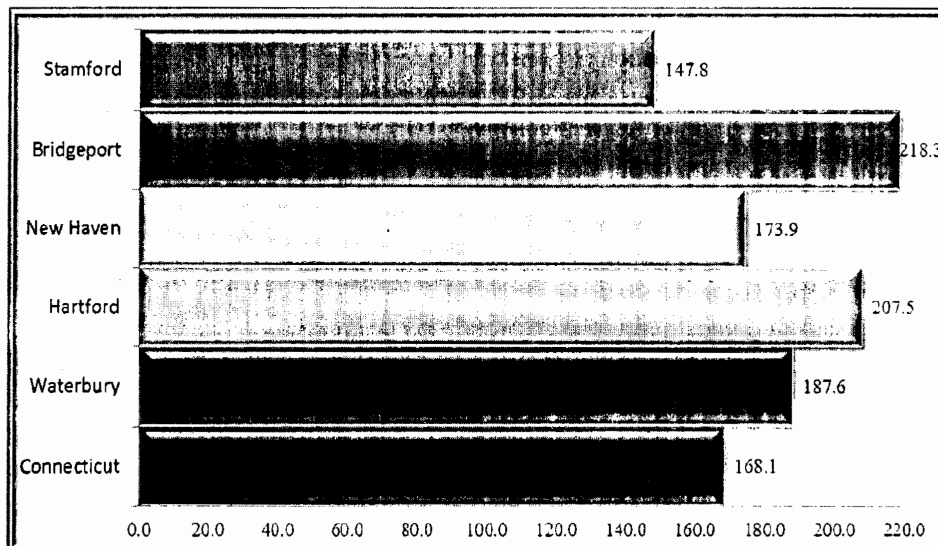


Figure 8. Deaths due to diseases of the heart per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

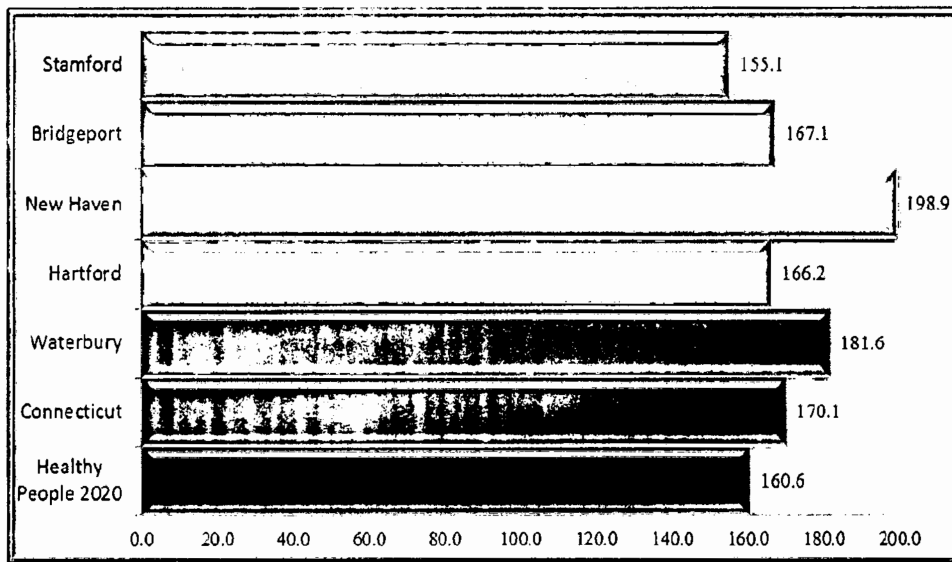


Figure 9. Deaths due to malignant neoplasms (cancer) per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011; Healthy People 2020, 2012;
Connecticut Department of Public Health, n.d.

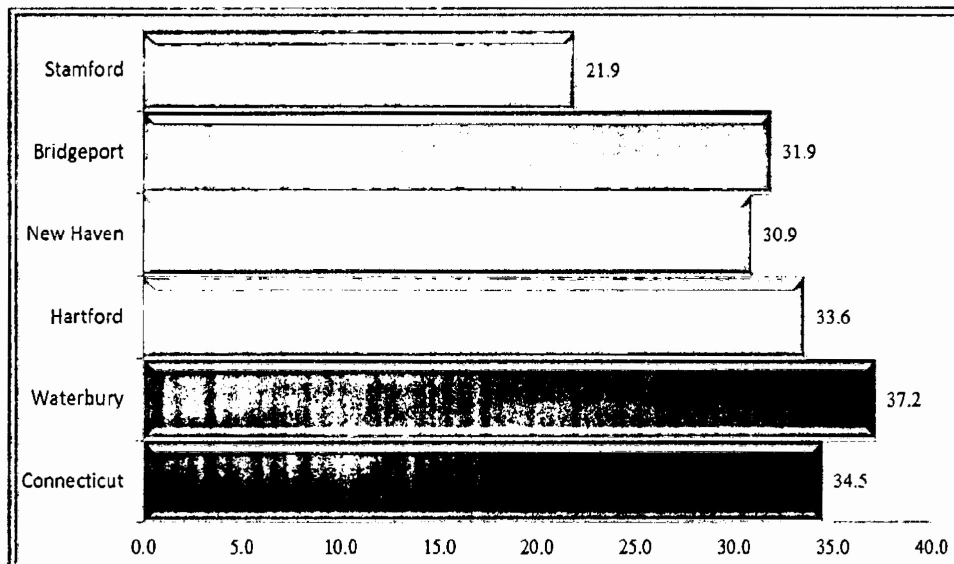


Figure 10. Deaths due to chronic lower respiratory disease per age-adjusted 100,000, 2005-2009
Sources: Center for Disease Control and Prevention, 2011
Connecticut Department of Public Health, n.d.

Maternal & Infant Health

The birth rate per 1,000 in Waterbury (15.7) is higher when compared to Connecticut (11.0), but similar to or lower than peer cities. Of the births that occur, 4.9% are to mothers less than 18 years of age and 14.5% are to mothers less than 20 years of age. These percentages are higher than what is seen across Connecticut (2.0% and 6.8% respectively) and all peer cities, excepting Hartford. The majority of teenage births are to mothers of Black and/or Hispanic race/ethnicity. Overall, the findings for teenage birth for the most recent year of data are negative, but births to teenagers less than 18 years of age have been trending downwards since 2005 (Connecticut Department of Public Health, 2011).

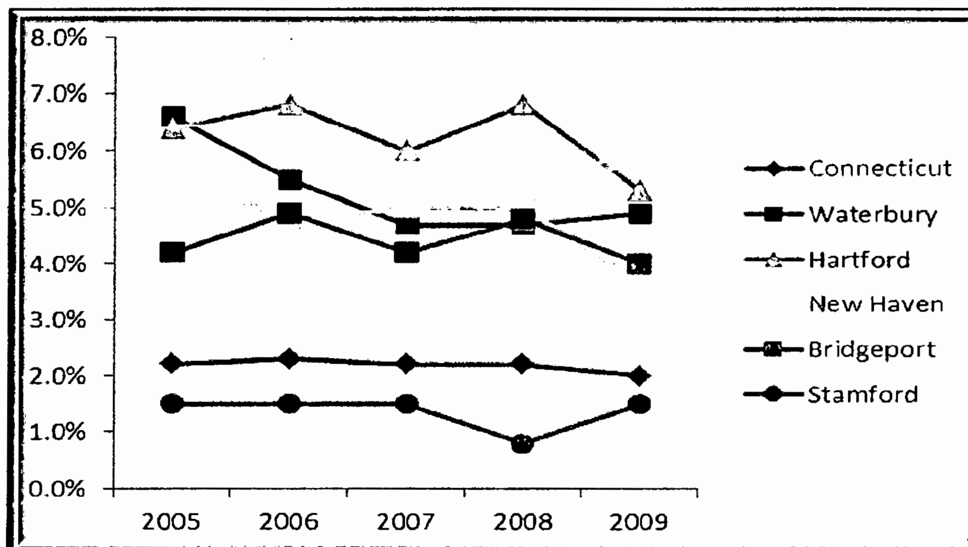


Figure 11. Births to teenagers less than 18 years, 2005 - 2009
Source: Connecticut Department of Public Health, 2007 - 2011

A total of 16 infant deaths occurred in Waterbury for a rate of 9.5 per 1,000 live births. This is higher when compared to Connecticut (5.6) and the Healthy People 2020 goal (6.0). The majority of infant deaths was among White infants (11 deaths, rate of 8.6) and occurred in the neonatal phase (within the first 27 days after birth). Seven Hispanic infant deaths also occurred in Waterbury for a rate of 10.4. This compares to a rate of 7.1 across all of Connecticut. In general, infant mortality has trended upwards in Waterbury since 2005 (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Related to infant mortality is birth weight. The percentage of infants born with low birth weight in Waterbury (10.0%) is higher when compared to Connecticut (8.1%), the Healthy People 2020 goal (7.8%), and every peer city except Hartford (10.5%). In particular, the percentage of Black infants born with low birth weight (14.6%) and very low birth weight (4.1%) is notably higher compared to Connecticut (12.0%; 3.2%) and all peer cities. Low birth weight has been on the rise in Waterbury since 2005, particularly for Black infants (Connecticut Department of Public Health, 2011 & Healthy People 2020, 2012).

Despite primarily negative findings related to teenage birth, infant mortality, and birth weight, Waterbury mothers are more likely to receive adequate and intensive prenatal care than mothers across Connecticut. This is true for mothers of White, Black, and Hispanic race/ethnicity. Mothers receiving late or no prenatal care has been on the decline in Waterbury since 2005 (Connecticut Department of Public Health, 2011).

Sexually Transmitted Illnesses

Sexually transmitted illness rates per 100,000 are notably higher in Waterbury than in Connecticut, particularly for chlamydia and gonorrhea. The chlamydia rate is 720.5 in Waterbury compared to 344.9 in Connecticut and the gonorrhea rate is 225.9 in Waterbury compared to 72.6 in Connecticut. The Waterbury rates are more favorable compared to peer cities. The chlamydia rate alone is as high as 1,220.3 in New Haven and 1,513.8 in Hartford (Connecticut Department of Public Health, n.d.). The following chart illustrates this difference.

Table 3. Sexually Transmitted Illness Cases per 100,000 (2009, 2010)[a]

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
HIV	11.4	17.2	54.5	31.6	33.3	11.4
Gonorrhea	72.6	225.9	403.0	363.3	239.6	37.2
Chlamydia	344.9	720.5	1,513.8	1,220.3	863.8	268.5
Primary/Secondary Syphilis	1.8	1.9	6.4	3.2	4.4	2.5

Sources: Connecticut Department of Public Health, n.d.

[a] All statistics represent 2009 data with the exception of HIV, which represents 2010 data

Mental Health Statistics

The suicide rate is considered to be an indicator of the mental health status of an area. The suicide rate per 100,000 in Waterbury is 8.6, which meets the Healthy People 2020 goal of 10.2, but is higher than Connecticut (7.8) and all peer cities (5.5 – 8.4). The suicide rate is a negative finding, but it should not be considered an all-encompassing indication of the mental health status of Waterbury. Additional indicators from the household telephone survey, focus groups, and key informant interviews should be considered for a more comprehensive understanding (Connecticut Department of Public Health, n.d. & Healthy People 2020, 2012).

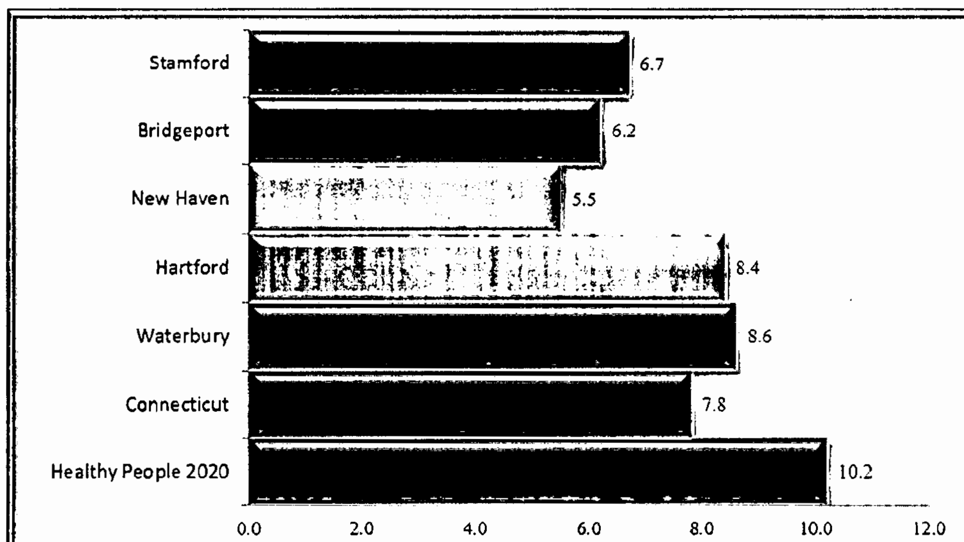


Figure 12. Suicide rates per 100,000, 2005 - 2009
Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Cancer Statistics
Cancer affects Waterbury residents at a rate of 484.3 per 100,000 and is the second leading cause of death. Overall, the total cancer incidence rate of 484.3 is similar to or lower than that of Connecticut and peer cities. However, lung cancer disproportionately affects Waterbury residents at a rate of 81.2 compared to 74.3 across Connecticut and a range of 45.0 – 67.5 across all peer cities (Connecticut Department of Public Health, n.d.). The following chart depicts incidence rates for all reported cancer types.

Table 4. Cancer Incidence by Site per 100,000 (2007)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	155.6[a]	134.8[a]	83.7[a]	118.9[a]	107.8[a]	155.8[a]
Colorectal	51.3	51.3	33.7	37.9	43.2	65.0
Lung	74.3	81.2	45.0	55.7	64.4	67.5
Prostate	173.3[a]	76.2[a]	119.5[a]	116.8[a]	128.6[a]	178.8[a]
All sites	**561.6**	**484.3**	**335.6**	**445.4**	**443.3**	**534.3**

Source: Connecticut Department of Public Health, n.d.
[a]Rates based on 2010 population counts

In contrast to the overall cancer incidence rate, the overall cancer mortality rate is higher in Waterbury than in Connecticut and all but one peer city, New Haven. The mortality rate per 100,000 for all cancer types is 181.6 in Waterbury compared to 170.1 across Connecticut and a range of 155.1 – 167.1 across Bridgeport, Stamford, and Hartford. Lung cancer presents as an area of concern again as the mortality rate for this condition is notably higher in Waterbury

(53.5) compared to Connecticut (45.0), Healthy People 2020 (45.5), and all peer cities (36.5 – 44.1) (Connecticut Department of Public Health, n.d.).

Table 5. Cancer Mortality by Site per 100,000 (2005 - 2009)

	HP 2020	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Female breast	. 20.6	N/A	12.8	11.0	17.9	14.5	11.7
Colorectal	14.5	14.6	15.9	16.4	18.5	13.8	12.8
Lung	45.5	45.0	53.5	42.2	44.1	43.3	36.5
Prostate	21.2	N/A	7.7	8.9	11.8	7.2	9.1
Skin	N/A	2.6	N/A	N/A	N/A	N/A	N/A
All sites	160.6	170.1	181.6	166.2	198.9	167.1	155.1

Sources: Connecticut Department of Public Health, n.d.
Healthy People 2020, 2012

Environmental Health Statistics

The environment that residents live, work, and play in can have a profound impact on their health. An indicator of the environmental health of an area is the prevalence of asthma. In Waterbury, the rate per 100,000 for emergency department visits due to asthma is 144.0 in adults 18 years and over and 197.3 in children under 18 years. This is notably higher than Connecticut's rates for adults and children (44.7 and 61.3 respectively) and most peer cities. Among adults in Waterbury, females, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma. Among children in Waterbury, males, Blacks/African Americans, and Hispanics are more likely to have visited an emergency department for asthma (Connecticut Department of Public Health, 2009).

Table 6. Emergency Department Visits due to Asthma per 10,000 (2001 – 2005)

	Connecticut	Waterbury	Hartford	New Haven	Bridgeport	Stamford
Population 18 +	44.7	144.0	182.8	108.8	126.7	41.5
Population <18	61.3	197.3	241.7	213.8	165.9	80.8

Source: Connecticut Department of Public Health, 2009

Another indicator of the environmental health of an area is the presence of food deserts, which are defined by Census tracts. Food deserts are areas that have little or no access to fully-stocked grocery stores that offer fresh, healthy, and affordable foods. In Waterbury, a number of census tracts have large populations living in food deserts. However, census tract 9009352400 is of particular concern. It has the highest percentage of residents living in a food desert across four out of the five reported categories (United States Department of Agriculture, 2010).

Table 7. Food Deserts by Census Tracts in Waterbury, Connecticut (2012)

	Population with low access to nutritious food sources	Population with low income and low access	Population 0-17 years with low access	Population 65+ years with low access	Population with no vehicle and low access
9009352400	100.0%	12.7%	31.6%	9.7%	16.4%
9009352300	21.3%	2.5%	5.2%	2.5%	3.4%
9009352200	55.1%	18.5%	24.2%	2.9%	14.2%
9009352100	33.7%	5.4%	9.5%	4.7%	3.6%
9009351800	57.7%	3.6%	10.8%	9.5%	3.7%
9009351500	45.9%	5.6%	11.7%	7.4%	7.0%
9009352800	33.4%	2.8%	11.4%	2.4%	4.3%

Source: United States Department of Agriculture, 2010

Secondary Data Profile Summary of Findings

The secondary data profile provided valuable context regarding how socioeconomic factors like income, education levels, and housing may influence local health outcomes. In Waterbury, the median income for households and families is higher; fewer residents live in poverty when compared to most peer cities. Residents are also less likely to rely on social assistance programs like Medicaid and State Administered General Assistance medical. In terms of health outcomes, Waterbury has lower rates of stroke mortality and sexually transmitted illness incidence. Waterbury has a number of strengths and assets, but it also has some areas to improve upon. In particular, Waterbury residents have more respiratory health issues and issues related to maternal and child health. In relation to respiratory health, residents are more likely to have visited an emergency department for asthma complications and to have died from lung cancer and chronic lower respiratory disease. Related to maternal and child health, the infant mortality rate is higher, infants are more likely to be born with low or very low births weight, and the number of teenage pregnancies is higher. Additional areas of concern in Waterbury are the suicide rate and food deserts, particularly in census tract 9009352400.

HOUSEHOLD TELEPHONE SURVEY OVERVIEW

Background

A statistical Household Telephone Survey was conducted based on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national initiative, conducted annually at the state level. The survey assesses self-reported health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.

For the Waterbury study, trained interviewers conducted telephone interviews between May and June 2013 by trained interviewers. Participants were randomly selected for participation based on a statistically valid sampling frame that included landline and cell phone telephone numbers. Only respondents who were at least 18 years of age and lived in a private residence were included in the study. A total of 1,121 individuals who reside within specific Zip codes served by the Greater Waterbury Health Improvement Partnership were interviewed by telephone. Select participant demographics are included in Appendix C.

The customized survey tool consisted of approximately 100 factors selected from BRFSS tool. A few customized questions were added to gather information about health issues specific to the service area. Depending upon interviewees' responses, interviews ranged from approximately 15 to 30 minutes in length.

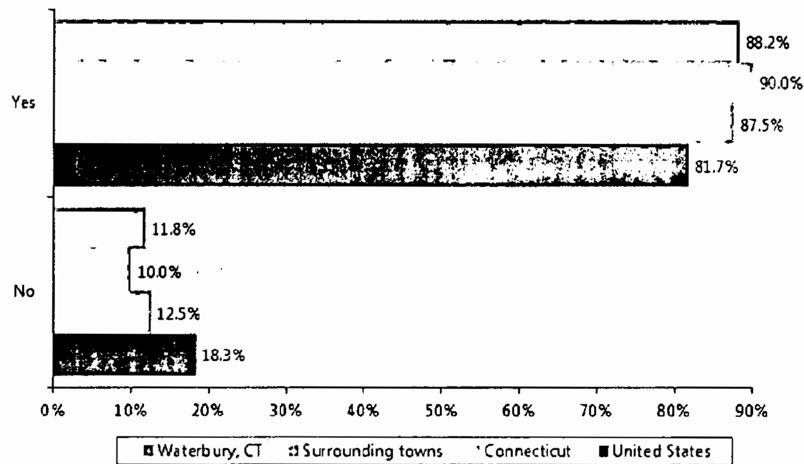
Statistical considerations for the study can be found in Appendix B. The following section provides a summary of the Household Telephone Survey results. A full report of the Household Telephone Survey results is available in a separate document.

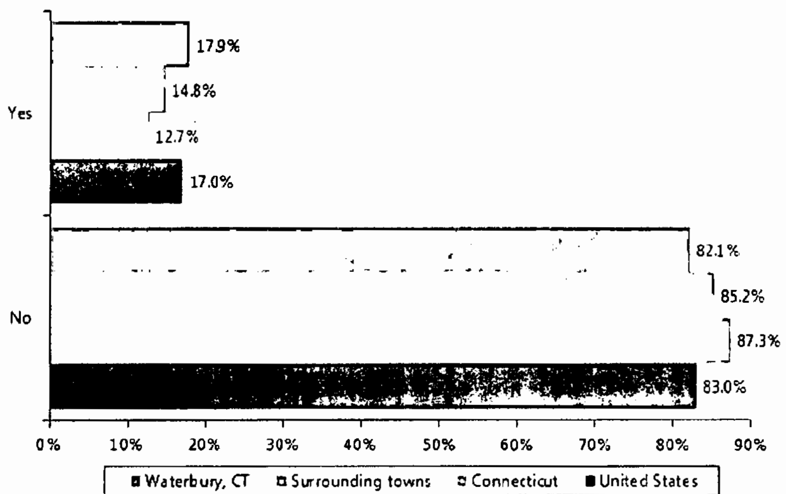
Household Telephone Survey Key Findings

The following section provides an overview of key findings from the Household Telephone Survey including highlights of important health indicators and health disparities.

Access to Health Care

Overall, residents of Waterbury are just as likely or more likely to have health care coverage (88.2%) and at least one person who they think of as their personal doctor or health care provider (84.1%) when compared to the state (87.5%; 85.2%) and the nation (81.7%; 78.0%). Local residents are also more likely to have received a routine checkup within the past year (76.6%) compared to the state (70.4%) and the nation (66.9%). Despite primarily positive findings regarding health insurance and access to primary care, residents of Waterbury still cite the cost of care as a barrier. Nearly 18% of respondents said that there was a time in the past 12 months when they needed to see a doctor but could not because of cost. This may be an indicator that out-of-pocket expenses that are not covered by insurance (e.g. copays) are preventing residents from seeking care when they need it.

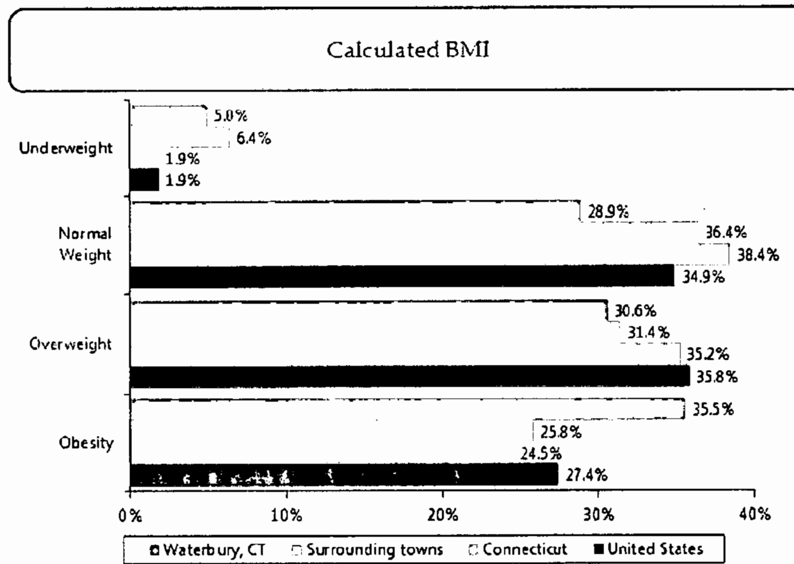




Health Risk Factors

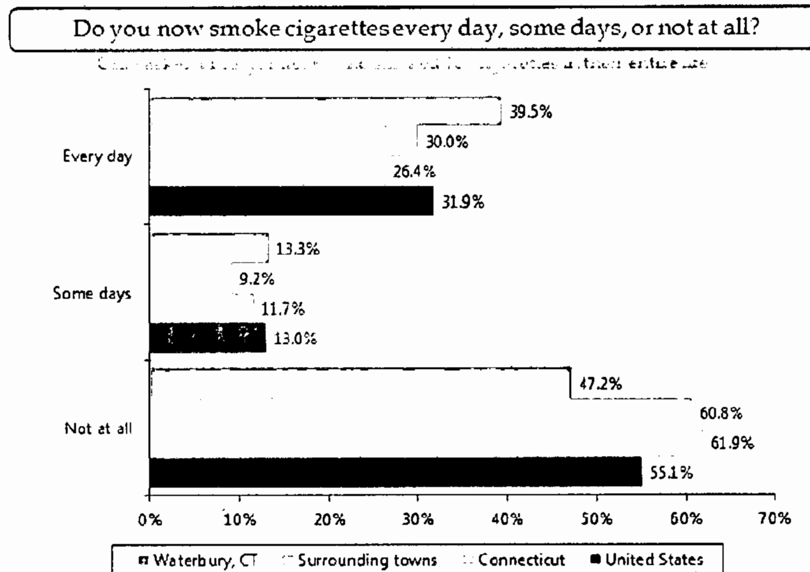
Obesity & Physical Activity

Obesity and its connection to serious medical conditions has become a national concern. In the latest BRFSS study, 63.2% of the nation and 59.7% of Connecticut was considered overweight or obese. Waterbury surpasses both with 66.1% of respondents considered overweight or obese and 35.5% considered obese. In addition, fewer respondents (68.9%) reported engaging in physical activity during the past month compared to the state (74.5%) and the nation (74.3%).



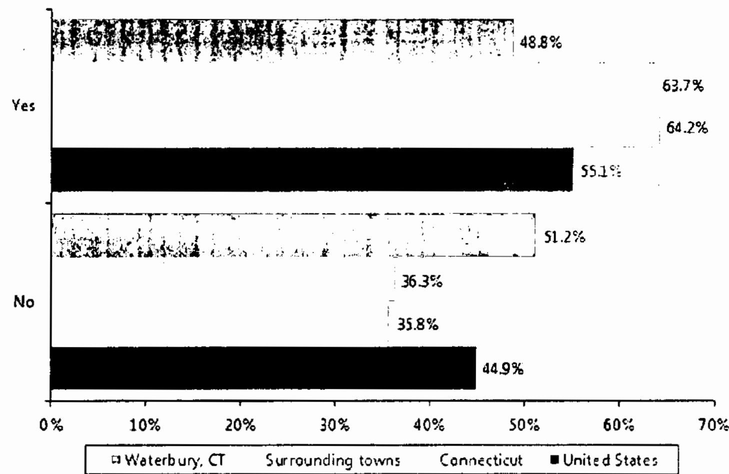
Tobacco & Alcohol Use

Tobacco use is a concern in Waterbury for both the proportion of residents who initiate smoking and the proportion who continue to smoke on a daily basis. More than half (51.1%) of Waterbury respondents have smoked at least 100 cigarettes in their lifetime compared to 45.0% across the state and 44.8% across the nation. In addition, more than half (52.8%) of the respondents who initiated smoking at some point in their lifetime still smoke every day or some days compared to the state (38.1%) and the nation (44.9%). A positive finding is that respondents are more likely to have attempted to quit smoking during the past 12 months.



Alcohol use and abuse is not as prevalent. Only 48.8% of respondents had an alcoholic beverage during the past 30 days compared to 64.2% across Connecticut and 55.1% across the nation. Of the individuals who did consume alcohol, fewer did so on a daily basis or participated in binge drinking, and more than half had a maximum of one to two drinks at a time.

During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?

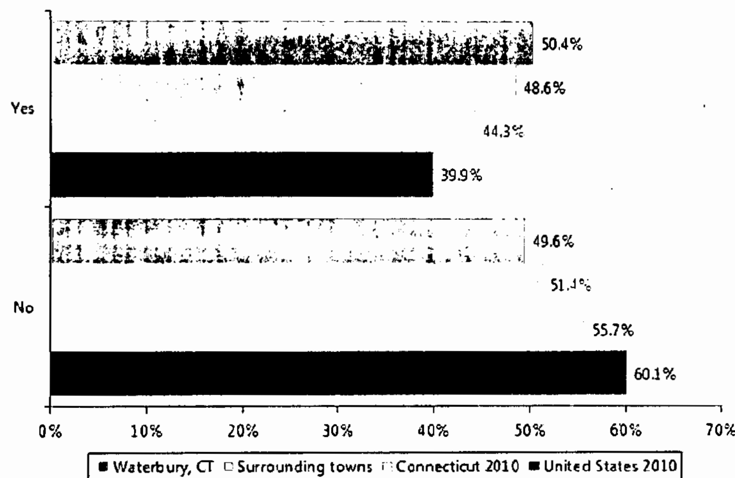


Preventive Health Practices

<u>Immunizations</u>

A positive finding among Waterbury respondents is the prevalence of immunizations. In the past 12 months, 51.8% of respondents received a flu vaccine either as a shot or a nasal spray compared to 45.2% in Connecticut and 41.3% in the nation. In addition, 35.5% received a pneumonia shot compared to 30.9% in Connecticut and 30.6% in the nation.

During the past 12 months, have you had a seasonal flu shot?



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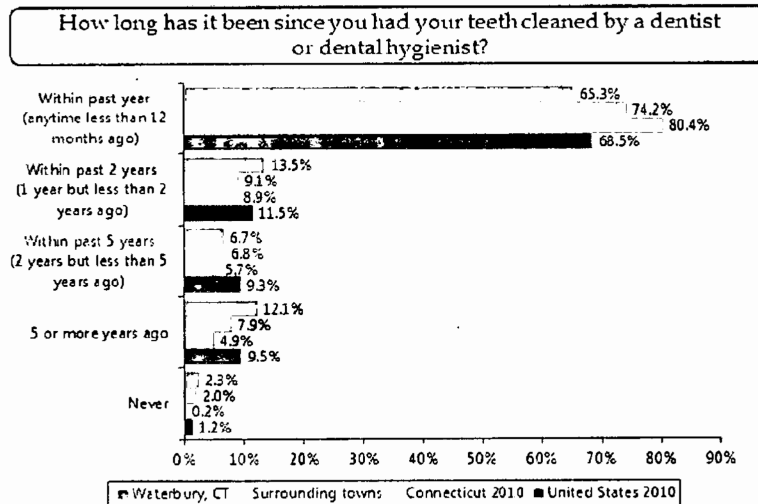
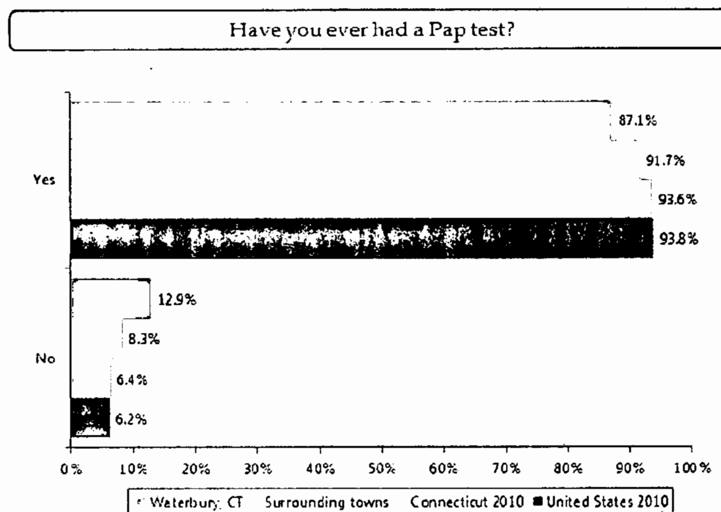
Screenings

In general, Waterbury residents are less likely to engage in preventative oral health practices. Only 60.8% of respondents visited a dentist or a dental clinic within the past year. This is consistent with the nation (68.1%), but notably lower when compared to Connecticut (80.6%). Waterbury respondents are also less likely to have had their teeth cleaned (65.3%) within the past year when compared to both the state (80.4%) and the nation (68.5%).

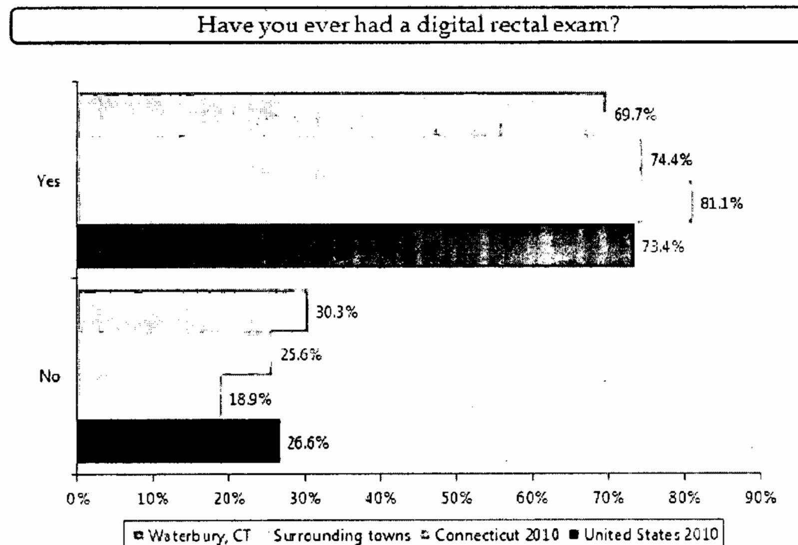


Female preventative screenings are also less prevalent among Waterbury residents. Women are less likely to have ever received a mammogram, clinical breast exam, or Pap test when compared to women across Connecticut and the nation. The percentage of Waterbury women receiving a Pap test is of particular concern as only 87.1% have ever had one compared to 93.6% in Connecticut and 93.8% in the nation. The percentage of women receiving clinical breast exams (87.8%) is also concerning when compared to all of Connecticut (92.4%).



Men ages 39 and older have a greater risk for prostate cancer and should receive regular diagnostic screenings. Male respondents in Waterbury are more likely to have had one of the suggested screenings, a prostate-specific antigen test (57.5%), when compared to men across the nation (51.1%). However, they are less likely to have the second suggested screening, a digital rectal exam (69.7%), when compared to men across Connecticut (81.1%) and the nation (73.4%). In addition, of the men who have had a digital rectal exam, fewer had it within the past year. This is a potential health concern since male respondents in Waterbury are more likely to have prostate cancer (6.0%) when compared to the nation (3.5%).

Have you ever had a digital rectal exam?



Colorectal cancer can be screened for through home blood stool tests and sigmoidoscopies/ colonoscopies. Waterbury respondents are slightly more likely to have had a sigmoidoscopy/ colonoscopy when compared to the nation, but notably less likely to have had a home blood stool test (27.7%) when compared to the nation (45.4%). Of those respondents who have had a home blood stool test, a large proportion last had one five or more years ago (35.0%).

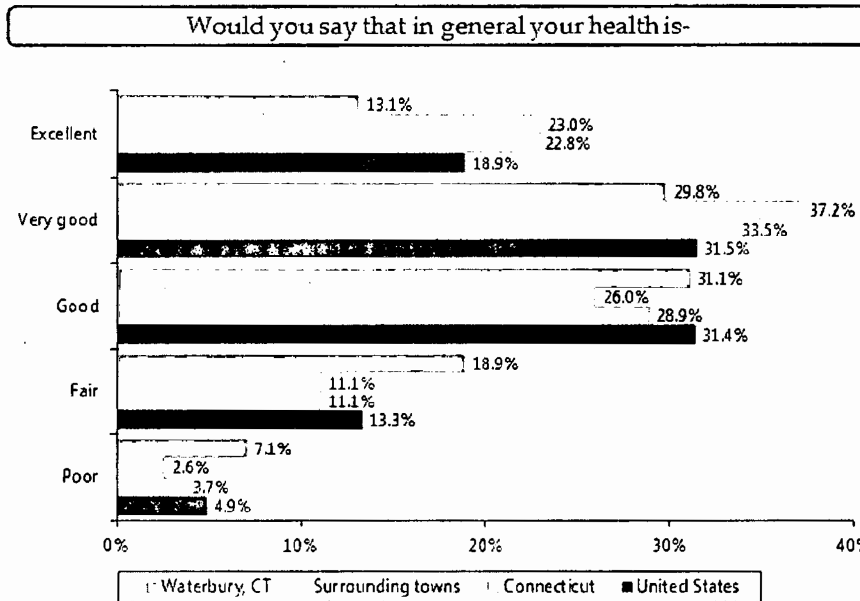
Residents in Waterbury are more likely to have been tested for HIV (55.7%) when compared to residents across Connecticut (36.7%) and the nation (37.4%). By itself, this is a positive finding. However, additional data suggests that a possible reason for higher screening rates is the prevalence of high risk behaviors. Approximately 7% of Waterbury respondents said that high risk situations like intravenous drug use and sexually transmitted diseases apply to them. This compares to 3.6% across Connecticut and 3.8% across the nation.

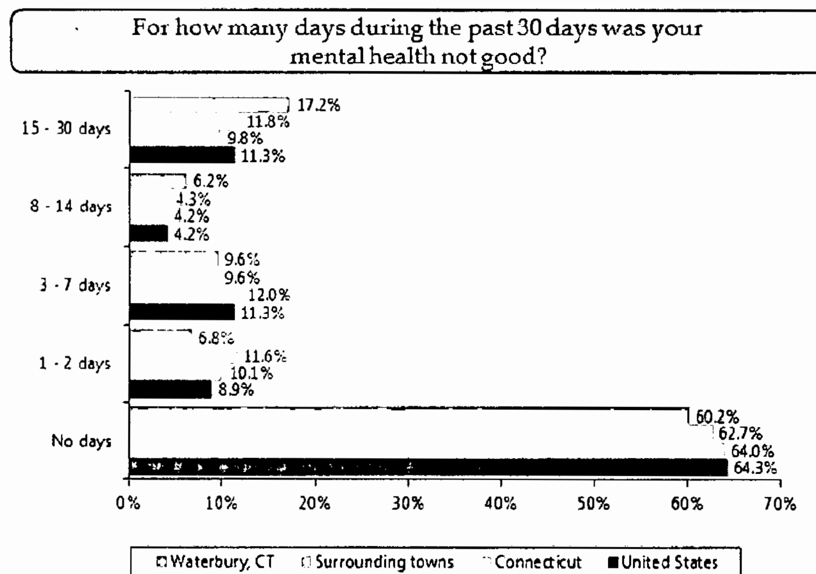
Health Status & Chronic Health Issues

Physical & Mental Health

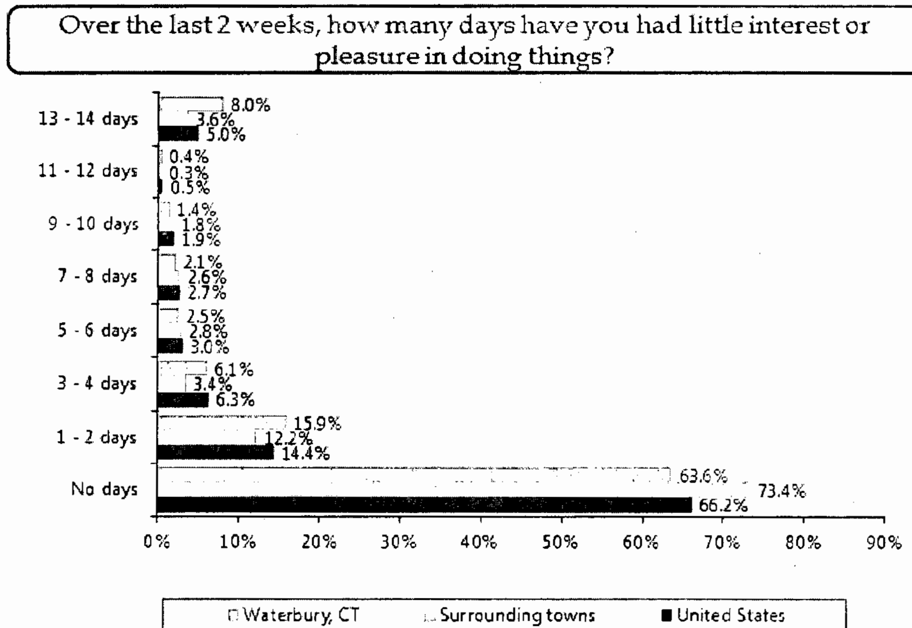
Residents of Waterbury are more likely to report having fair or poor health in general. Only 13.1% of respondents said that their health was excellent, compared to Connecticut (22.8%) and

the nation (18.9%). In addition, during the past 30 days, 40.8% of respondents said that they had at least one day of poor physical health and 39.8% said that they had at least one day of poor mental health. Of particular concern is the 17.2% of respondents who said that they had 15 – 30 days of poor mental health during the past 30 days. This compares to 9.8% across Connecticut and 11.3% across the nation. The combination of poor physical and mental health days kept 45.3% of respondents from doing their usual activities on at least one of the past 30 days.





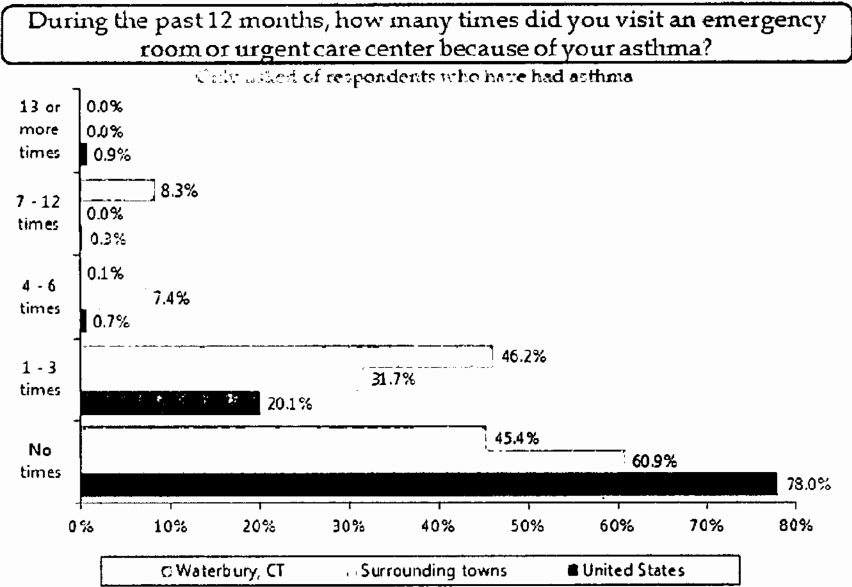
In addition to having more days of poor mental health, Waterbury respondents are more likely to have been diagnosed with an anxiety disorder and to have felt depressed and had little interest in doing things. The percentage of Waterbury respondents who have been diagnosed with an anxiety disorder is 19.7%. This compares to 16.7% across the nation. Over the last two weeks, 36.4% of respondents had little interest or pleasure in doing things and 34.3% felt down, depressed, or hopeless. A positive finding is that more respondents (16.4%) are taking medicine or receiving treatment from a health professional for their mental health condition when compared to the nation (12.5%).



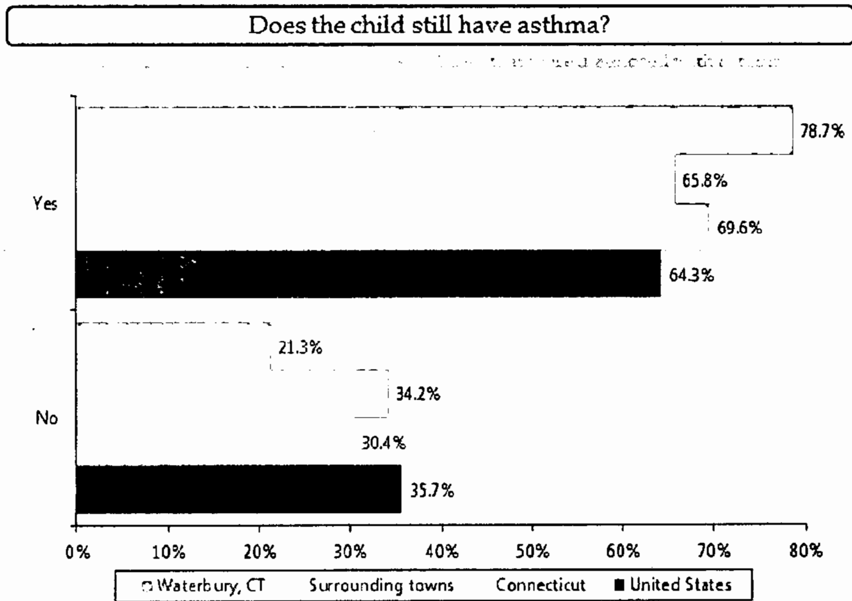
A contributing factor to the poor mental health status of Waterbury residents may be the proportion of residents who are acting as caregivers for friends or family members. During the past month, 27.1% of respondents provided caregiver services compared to 15.6% across Connecticut and 16.8% across the nation.

Chronic Health Issues

A number of chronic conditions are of concern in Waterbury, including asthma, cardiovascular disease, and diabetes. Approximately 22% of Waterbury respondents had been told that they have asthma. This compares to 14.8% in Connecticut and 13.5% in the nation. Additional data also suggests that asthmatics in Waterbury are not managing their condition as well. A higher proportion have had an asthma attack (59.2%) and visited an emergency room or urgent care center in the past year (54.6%) when compared to the nation (43.0%; 22.0%). A higher proportion has also been unable to carry out their usual activities because of their asthma (39.5%) when compared to the nation (23.8%).

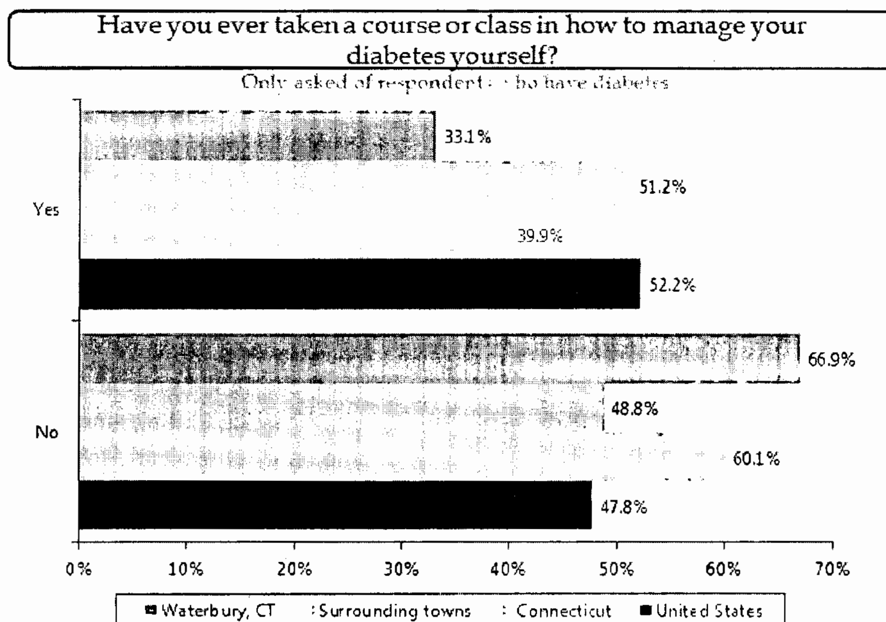


Children in Waterbury are also disproportionately affected by asthma. Slightly more than 21% have been diagnosed with asthma compared to 15.0% in Connecticut and 13.4% in the nation. They are also more likely to still have asthma (78.7%) when compared to Connecticut (69.6%) and the nation (64.3%).



Residents in Waterbury are more likely to have cardiovascular health issues like heart attacks (6.6%), angina or coronary heart disease (5.9%), and stroke (5.4%). A contributing factor (other than obesity and lack of physical activity) may be high blood pressure. A higher proportion of Waterbury residents have high blood pressure (33.6%) when compared to Connecticut (29.7%) and the nation (31.6%) and fewer are taking medicine for it.

A higher proportion of residents in Waterbury have been diagnosed with diabetes (14.8%) when compared to Connecticut (9.3%) and the nation (9.8%). This is a concern for the community in terms of prevention, but even more concerning is that diabetics in Waterbury are less likely to manage their condition. Fewer diabetics are taking insulin, checking their blood glucose levels on a daily basis, seeing a health professional for their condition, having a health professional conduct an A1C test or foot check, and attending self-management courses. Specifically, only 33.1% of diabetic respondents have taken a course in how to manage their diabetes compared to 39.9% of diabetics across Connecticut and 52.2% of diabetics across the nation.



Household Telephone Survey Summary of Findings

A number of areas of opportunity were identified through the household telephone survey. The first area was access to care. Residents are more likely to have trouble affording out-of-pocket expenses despite having equitable health insurance coverage. They are also less likely to receive preventive screenings related to oral health and women's health. The second area was chronic health conditions. Respiratory conditions presented as an issue with a higher proportion of residents saying that they and their children have asthma. A contributing factor to asthma rates may be the proportion of residents who smoke cigarettes. Cardiovascular disease and diabetes

also presented as concerns among residents. Contributing factors to these conditions may be the proportion of residents who are overweight or obese and have high blood pressure. The third area was the mental health status of Waterbury. Residents have more days of poor mental health, are more likely to experience depression and be diagnosed with an anxiety disorder.

FOCUS GROUPS OVERVIEW

Background

A total of six focus groups were held at various locations throughout Waterbury in February 2013. Two of the groups were conducted with health care providers associated with the two hospitals; four groups were conducted with members of neighborhood associations. Focus group topics addressed access to care, cultural competency, physical activity, nutrition/healthy eating habits, weight/obesity, and health information. Each session lasted approximately 90 minutes and was facilitated by trained staff from Holleran.

Participants were recruited through the CHNA partners. In exchange for their participation, health care providers were given a $25 gift card; community members received $25 cash. Two discussion guides developed in consultation with the Greater Waterbury Health Improvement Partnership, were used to prompt discussion and guide the facilitation.

In total, 57 people participated in the focus groups. It is important to note that the results reflect the perceptions of a limited number of providers and community members and may not necessarily represent all providers and residents of Waterbury.

The following section provides a summary of the focus group discussions including key themes and select comments.

Health Care Provider Focus Groups Key Findings

Access to Care

Access to care was an area of shared concern among Saint Mary's and Waterbury Hospital physicians. Physicians agreed that the greatest barriers to accessing care in Waterbury are an inadequate number of physicians, particularly primary care physicians, and health insurance-related issues. The primary care shortage in Waterbury has prohibited patients from having assured and timely access to care, even if they are insured. Many patients with medical homes are still using the ED due to the limited hours of clinics and the overwhelming demand for limited appointment slots. Participants also pointed out that primary care physicians are the lowest paid providers and care for the most challenging payer mix.
Participants shared that low Medicaid reimbursements limit the number of patients that primary and specialty physicians are willing to see. One physician stated, "It costs us more to see the

patients than what we receive in reimbursement." Additional barriers to accessing care included a lack of awareness of available services among eligible patients, limited bilingual services for non-English speaking residents, transportation, and co-payments. Another physician stated, "Even residents with health insurance are financially stressed and don't follow through on their care due to copayment costs."

There was general consensus among providers that patients with mental and/or behavioral health issues are underserved. It is difficult for these patients to receive the care that they need because providers are hesitant to "take responsibility for them" and services are limited. Providers are reluctant to be the "physician of record." Other underserved populations included the seasonally insured, service industry workers, and minority populations.

Participants listed a number of resources for uninsured and underinsured residents. The Waterbury Health Access Program (WHAP) was seen as particularly successful in linking needy patients with volunteer physicians and insurance. Lack of funding could jeopardize the future of the program.

Key Health Issues and Challenges

Mental and behavioral health issues were seen as key health issues in the community. One physician suggested that there was "widespread emotional despair" within the city. Other concerns were that elderly patients suffered from dementia, late-stage breast cancer diagnoses, and obesity.

Related to obesity, participants saw a number of challenges for residents trying to stay physically fit and eat a healthy diet. Fresh fruits are expensive and not widely available following recent closings of several supermarkets. An increase in farmers' markets was seen as a positive development. Other barriers included residents' awareness of healthy diets, as well as their willingness to dedicate resources to costly fruits and vegetables (over less expensive fast food alternatives). Compounding challenges to maintaining health, a lack of accessible, safe recreational areas was noted.

Participants provided several recommendations for improving the health of the community. Better patient navigation, extended clinic hours to serve residents instead of the ED, and higher reimbursement for Medicaid patients, were among recommendations provided. Participants agreed that mental health treatment options also needed to be expanded. Investments to improve poor economic conditions in the city needed to continue.

Provider Resources

Providers agreed that insurance-related issues are one of the top obstacles that they face in providing care. The amount of paperwork required by each plan burdens medical offices and takes away from direct patient care. Providers also stated that a merger between the two hospitals in Waterbury would create more seamless care and financial stability that would allow for more modern technology.

Local health departments were viewed as helping to meet the needs of the Waterbury community; however, most participants were not aware of specific activities. The general consensus was that more support from entities across the community was needed. One participant stated, "It comes down to shared responsibility. Everyone needs to take a part."

Community Resident Focus Groups Key Findings

Access to Care

A number of issues were identified by community residents as barring people from accessing health care. Many issues were centered on the cost of care. Participants identified lack of health insurance, the cost of copayments and medications, and increasing premiums and deductibles, specifically. They also expressed concern that Husky Care (Medicaid) was often not accepted by providers and that people were "looked down upon" for having it. Other issues included transportation, clinic hours of operation, language barriers, lack of awareness of services, and legal status. Participants stated that it can "take all day" to see the doctor due to the limited number of bus stops and long wait times between rides. They also stated that the only place to receive care after hours was the ED since clinics and private medical offices were closed. Hispanics/Latinos and Albanian residents were viewed as most impacted by language barriers.

Participants felt that a number of populations within the community were not being adequately served by local health services. These included African Americans, Hispanics/Latinos, single mothers with children, the homeless, mentally ill residents, seniors, and teens. Participants explained that for those seniors who need assistance with Activities of Daily Living (ADL), traveling to the Veteran's Administration Hospital in West Haven (45 minutes away) is a burden. They also expressed that teens are often not able to afford medication and are struggling with issues like sexually transmitted diseases. Resources identified that cared for underserved populations included hospital EDs, health clinics, Planned Parenthood, and the Malta House of Care van.

Dental care and mental health care were viewed as lacking services in the community. Participants agreed that dental care is largely unavailable without insurance. There was general consensus that there was "no place to go" for mental health care services. One person stated, "You have to commit a crime to get mental health care."

Key Health Issues and Challenges

More than 10 health issues were identified as major concerns in the community. Among the issues, mental and behavioral health issues were mentioned several times. In particular, participants noted wide-spread abuse of medicines like Nyquil and addictions to pain medication. Several factors were seen as contributing to addictive behavior including long delays in getting appointments and automatic refilling of pain medication prescriptions. Participants also noted tobacco use as a major concern. They observed that "Everyone smokes

cigarettes." An increased popularity of small cigars due to the lower cost compared to cigarettes was noted.

Participants noted a number of challenges for people in the community trying to stay physically fit and eat healthier. There was broad agreement that Waterbury does not offer adequate opportunity for physical activity. Comments included: "There are no safe parks." "Sidewalks are not in good condition." "Streets are of an old design; they are not wheelchair or stroller friendly." "There are no bike trails." "Today's parks have crooked slides and broken sprinklers." "There are syringes on the ground."

Programs that are available for recreation have a cost associated with them. Two organizations, the Police Athletic League (PAL) and the YMCA, were seen as positive entities, although both have fees for participation. Participants agreed that fresh fruits and vegetables were available year-round, but that barriers like cost, transportation, and location keep residents from accessing them widely. The farmer's market was seen as a step in the right direction; however, one participant said "You have to fight your way through panhandlers and the homeless to shop there." One solution was to increase the number of community gardens in Waterbury.

A number of weaknesses related to the socio-economic and physical environment of the community were identified. Participants stated that there was a lack of jobs in the area and that youth didn't have work opportunities. Poverty conditions often caused parents to "hop from apartment to apartment" to avoid paying rent, causing school transfers and disruption to children's education. Blight, littering, and poor school conditions were also concerns. One participant stated, "Residents are not invested in the areas where they live."

Community Aspirations & Capacity

Participants offered a number of suggestions for improving the health of the community. Specific examples included expanding access to care by "bringing back" the StayWell Health Center van; sponsoring free dental clinics; offering more health screenings and smoking cessation programs; and promoting on-going health education campaigns. Cleaning up the city park, improving the transportation system, sponsoring more community gardens, and providing safe and clean public restrooms in the downtown area were suggested to improve the city environment.

Participants urged community organizations to concentrate on the city as a whole and work to improve the socio-economic factors burdening residents. They also cited the need for more general counseling services and community mentors for the youth. Participants thought that efforts needed to be made to "instill more pride in the city" in an effort to encourage more community involvement and advocacy. Religious organizations were seen as untapped resource in these efforts.

Focus Group Summary of Findings

The focus group participants were grateful for the opportunity to share their thoughts and experiences; many expressed support for community-wide efforts to improve the health status of Waterbury. Identified community strengths included area healthcare providers, specifically the hospitals, health clinics, and local health departments. Areas of opportunity included expanding access to care for residents, availability of resources to improve physical activity and healthy eating, and concerns of blight and community investment.

KEY INFORMANT INTERVIEWS OVERVIEW

Background

An online survey was conducted among area "Key Informants." Key informants were defined as community stakeholders with expert knowledge including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders.

Holleran staff worked closely with the Greater Waterbury Health Improvement Partnership to identify key informant participants and to develop the Key Informant Survey Tool. Two-hundred and five (205) completed surveys were collected between February and April 2013. A listing of key informant participants can be found in Appendix D.

The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across three key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

It is important to note that the results reflect the perceptions of some community leaders, but may not necessarily represent all community representatives within Waterbury.

Key Informant Study Findings

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top health issues that they perceived as being the most significant. The issues that were most frequently selected were:

1. Mental/Behavioral Health
2. Overweight/Obesity
3. Access to Health Care/Uninsured/Underinsured
4. Substance Abuse/ Alcohol Abuse
5. Heart Disease

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue as one of their top five issues. The first column depicts the total percentage of respondents that selected the health issue as one of their top five. Respondents were also asked of those health issues mentioned, which one issue is the most significant. The second column depicts the percentage of respondents that rated the issue as being the most significant of their top five.

Table 1: Ranking of Key Health Issues

Rank	Health issue	Percent of respondents who selected the issue	Percent of respondents who selected the issue as the most significant
1	Mental/Behavioral Health	78%	32%
2	Overweight/Obesity	66%	14%
3	Access to Health Care/ Uninsured/Underinsured	63%	26%
4	Substance Abuse/Alcohol Abuse	61%	7%
5	Heart Disease	42%	5%
6	Diabetes	41%	2%
7	Cancer	34%	7%
8	Caregiver Needs	30%	4%
9	Dental Health	21%	0%
10	Tobacco	20%	1%
11	Maternal/Infant Health	16%	1%
12	Stroke	11%	1%
13	Sexually Transmitted Diseases	7%	0%
14	HIV/AIDS	6%	1%

Figure 1 shows the key informant rankings of all the key health issues. The bar depicts the total percentage of respondents that ranked the issue in their top five.

"What are the top 5 health issues you see in your community?"

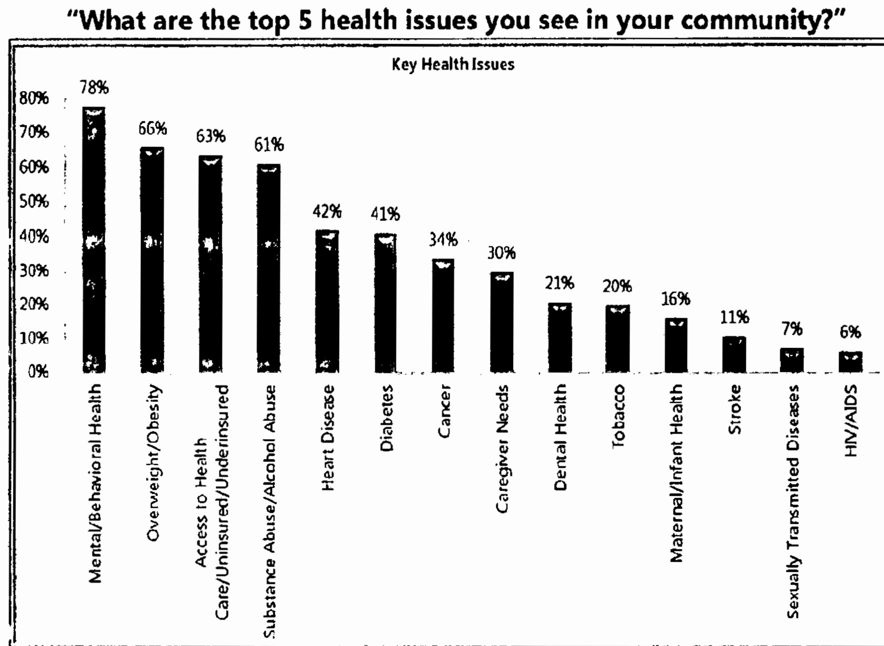


Figure 1: Ranking of key health issues

Health Care Access

Availability of Services

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bilingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in Table 2.

Health care access appears to be a significant issue in the community. As illustrated in Table 2, none of the informants strongly agree to any of the health care access factors. Most respondents 'Disagree', with community residents' ability to access care. Availability of mental/ behavioral health providers garnered the lowest mean responses (2.06), compared to the other factors.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access."

Table 2: Mean Responses for Health Care Access Factors

Factor	Mean Response	Corresponding Scale Response
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.19	Neither agree nor disagree
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.90	Disagree
Residents in the area are able to access a dentist when needed.	2.93	Disagree
There are a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.33	Disagree
There are a sufficient number of bilingual providers in the area.	2.40	Disagree
There are a sufficient number of mental/ behavioral health providers in the area.	2.06	Disagree
Transportation for medical appointments is available to residents in the area when needed.	2.53	Disagree

Barriers to Health Care Access

After rating availability of health care services, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Inability to Pay Out-of-Pocket Expenses (co-pays, prescriptions, etc.)
- Lack of Health Insurance Coverage
- Inability to Navigate Health Care System

Table 3 shows the breakdown of the number and percent of respondents who selected each barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier. The third column in the table depicts the percentage of respondents that rated the barrier as being the most significant facing the community.

"What are the most significant barriers that keep people in the community from accessing health care when they need it?"

Table 3: Ranking of Barriers to Health Care Access

Rank	Barrier to Health Care Access	Number of respondents who selected the issue	Percent of respondents who selected the issue	Percent of respondents who marked it as the most significant barrier
1	Inability to Pay Out of Pocket Expenses	151	80%	19%
2	Lack of Health Insurance Coverage	135	71%	20%
3	Inability to Navigate Health Care System	131	69%	26%
4	Lack of Transportation	107	57%	4%
5	Language/Cultural Barriers	86	46%	1%
6	Basic Needs Not Met (Food/Shelter)	80	42%	8%
7	Time Limitations	82	43%	3%
8	Availability of Providers/Appointments	80	42%	14%
9	Lack of Child Care	45	24%	1%
10	Lack of Trust	42	22%	2%

Figure 2 shows a graphical depiction of the frequency of selected barriers to health care access.

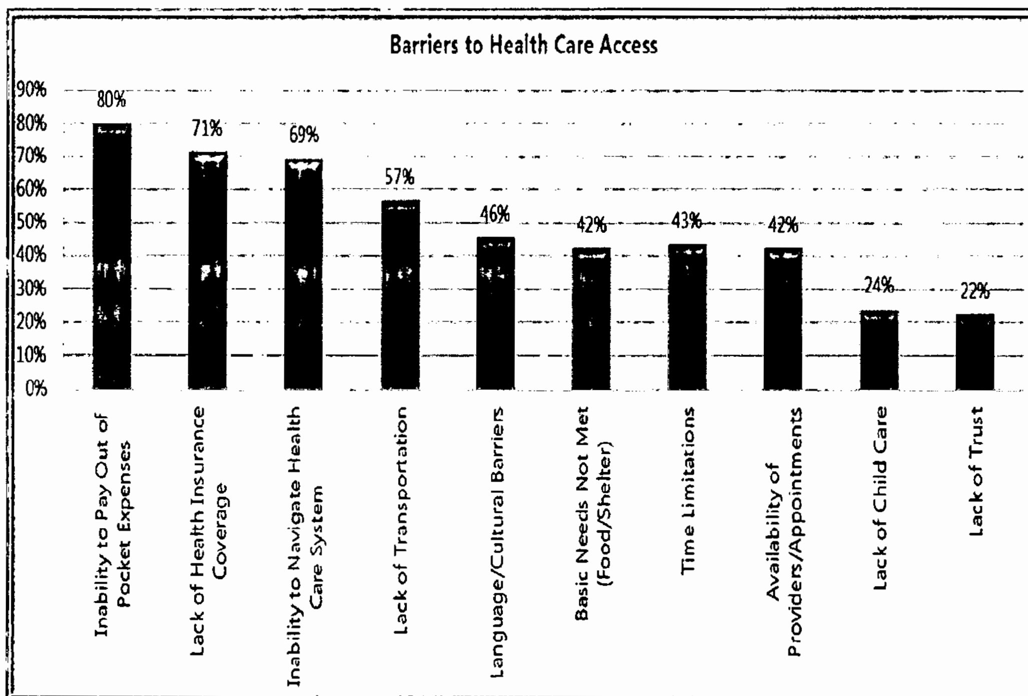


Figure 2: Ranking of barriers to health care access

Underserved Populations

Informants were then asked whether they thought there were specific populations who are not being adequately served by local health services. As seen in Figure 3, the majority of respondents (82%) indicated that there are underserved populations in the community.

"Are there specific populations in this community that you think are not being adequately served by local health services?"

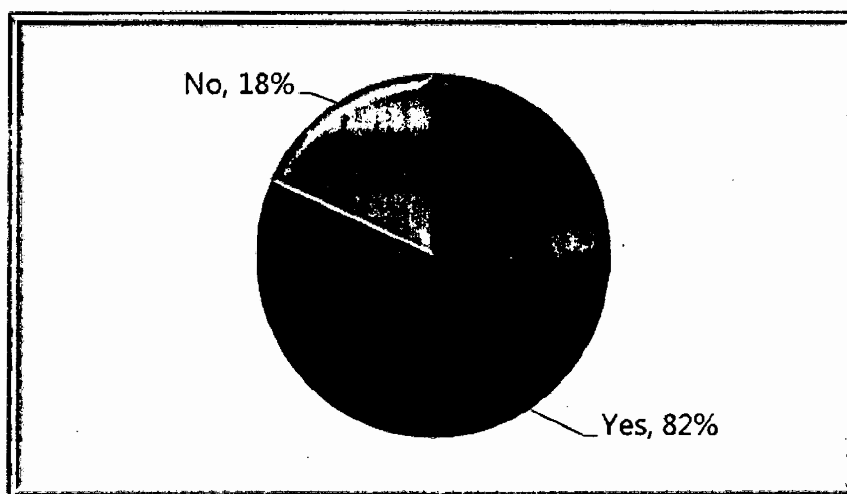


Figure 3: Key informant opinions regarding underserved populations

Those respondents were asked to identify which populations they thought were underserved. The results can be found in Table 4 below. Uninsured/underinsured and low-income/poor individuals were considered underserved populations along with homeless individuals and seniors/aging/elderly individuals. In addition, several respondents felt that racial/ethnic minorities and immigrant/refugee population were underserved.

Table 4: Underserved Populations

	Underserved population	Number of respondents selecting the population
1	Uninsured/Underinsured	98
2	Low-income/Poor	82
3	Homeless	64
4	Seniors/Aging/Elderly	41
5	Hispanic/Latino	35
6	Immigrant/Refugee	33
7	Black/African-American	31
8	Children/Youth	29
9	Disabled	28
10	Young Adults	22
11	Lower Middle Class	3
12	Mental Health/Addicts	1
13	Veterans	1
14	LGBT	1

Health Care for Uninsured/Underinsured

Next, the informants were asked to select where they think most uninsured and underinsured individuals go when they are in need of medical care. As shown in Figure 4, the majority of respondents (81%) indicated that uninsured and underinsured individuals go to the Hospital Emergency Department for medical care.

In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care?

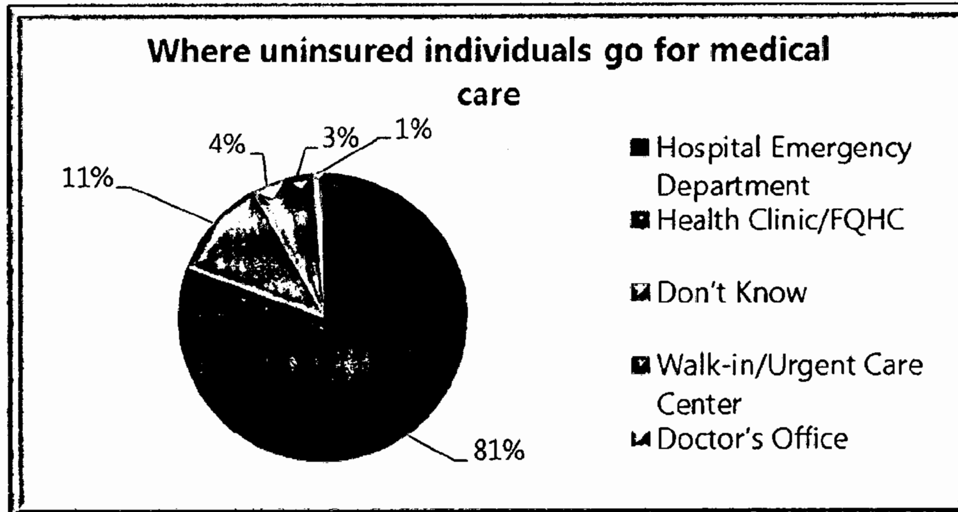


Figure 4: Key informant opinions of where uninsured individuals receive medical care

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many respondents indicated that free and low cost medical and dental care, and mental health services are needed. In addition, informants want to see more health education and outreach and more transportation/assisted transportation. Table 5 includes a listing of the resources mentioned ranked in order of the number of mentions.

Table 5: Listing of Resources Needed in the Community

Rank	Resources Needed	Number of Mentions
1	Free/Low Cost Dental Care	111
2	Mental Health Services	108
3	Free/Low Cost Medical Care	93
4	Health Education/Information/Outreach	78
5	Transportation/Assisted Transportation	69
6	Health Screenings	63
7	Bilingual Services	58
8	Prescription Assistance	58
9	Substance Abuse Services	52
10	Primary Care Providers	39
11	Medical Specialists	32
12	Free/Low Cost Dental Care	111

Challenges & Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community.

When asked what challenges people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort
- Education/Knowledge
- Chronic Conditions/Diseases
- Cultural Norms
- Environment/Safety

Next, key informants were asked "What recommendations or suggestions do you have to improve health and quality of life in the community?" Several major themes emerged from the comments including the following:

- Increased Awareness/Education/Community Outreach
- Increased Collaboration/Coordination
- Improved Access to Medical Care, Dental Care, and Mental Health Services
- Improved Access to Affordable Exercise and Nutrition Programs
- Need For Patient Navigation
- Enhanced Programs/Outreach for Youth and Seniors
- Enhanced Community Space

Key Informant Interviews Summary of Findings

Key informants acknowledged that mental/behavioral health, overweight/obesity, and access to care are the most significant health issues in the community. Related to access to care, informants agreed that residents do not have sufficient access to providers and experience a number of barriers in seeking care. In particular, they felt that residents are not able to see specialists, dentists, and mental/behavioral health providers when they need to. They also felt that there are not enough bilingual providers and providers accepting Medicaid and medical assistance. Additional barriers for residents seeking care are out-of-pocket expenses, lack of health insurance coverage, and the inability to navigate the health care system. Informants recommended a number of resources to improve access to care. Among these, free/low cost dental care, mental health services, and free/low cost medical care were cited the most.

Eighty-two percent of informants agreed that there are underserved populations living in Waterbury. Of these populations, they felt that the uninsured/underinsured, low-income/poor, and homeless are the most underserved. When seeking medical care, these populations were thought to most often utilize hospital emergency departments and federally qualified health centers/clinics.

The last portion of the survey asked key informants to identify challenges in the community in maintaining healthy lifestyles and to make recommendations or suggestions for improving health and quality of life. In addition to issues related to access to care, informants listed motivation/effort, education/knowledge, cultural norms, and environment/safety as challenges in the community. To address these issues, informants recommended increasing awareness, education, community outreach, and community collaboration and coordination. They also suggested that more programs for youth and seniors be offered and that the community space be enhanced.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS & PLANNING

Prioritization Session

On June 17, 2013, approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for the development of the hospital's Implementation Strategy. A list of attendees can be found in Appendix G.

Process

The prioritization meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. This overview presented the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were then asked to share openly what they perceived to be the needs and areas of opportunity in the city. Through facilitated discussion, attendees developed the following "master list" of potential priority areas for the implementation plans. Master list of community priorities (Presented in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

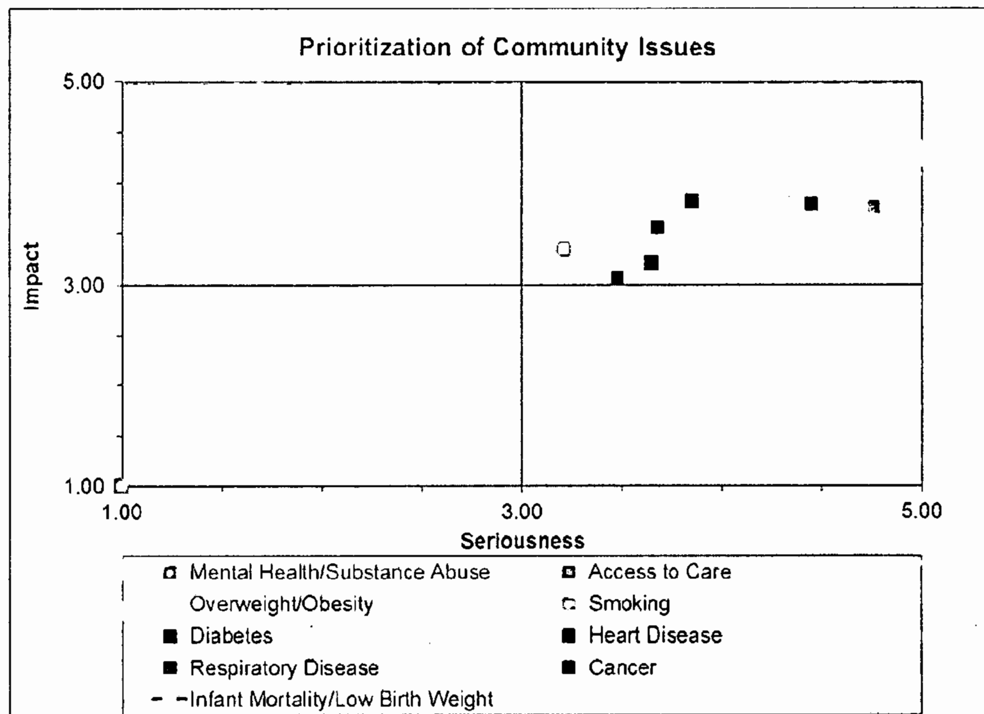
Key Community Health Issues

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included the seriousness of the issue and the community's ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.25 average rating), followed by Overweight and Obesity (4.13 average rating), and Access to Care (4.12 average rating). The ability to impact Overweight and Obesity was rated the highest at 3.94, followed by Diabetes with an impact rating of 3.82.

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Overweight/Obesity
- Tobacco Use

Goal Setting

Following the prioritization session, The Greater Waterbury Health Improvement Partnership representatives met to review the identified priorities and develop goal statements to guide community-wide health improvement efforts. The following goals were adopted for each priority area:

Access to Care
Goal: Improve access to comprehensive, culturally competent, quality health services.

Mental Health and Substance Abuse
Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Overweight and Obesity
Goal: Promote health and reduce chronic disease through healthful eating and physical activity.

Tobacco Use
Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Action Planning

To set a course for ongoing community health improvement activities and evaluation, a Community Health Improvement Plan (CHIP) was developed by the Greater Waterbury Health Partnership. Additionally, in line with requirements set forth in the ACA, specific Implementation Strategies, outlining how each hospital would work to address the identified needs, were created.

The CHIP and Hospital Implementation Strategies were adopted in September 2013. These documents, as well as a report of the CHNA are available on the partner websites.

APPENDIX A: Secondary Data Profile References

Bridge to Success. (2010). *Preparing Waterbury youth for life: A birth to 21 initiative.*

Centers for Disease Control and Prevention. (2011). *Mortality data.* Retrieved from http://www.cdc.gov/nchs/deaths.htm

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Connecticut Department of Public Health. (n.d.). *Cancer.* Retrieved from http://www.ct.gov/dph/taxonomy/v4_taxonomy.asp?DLN=47825&dphNav=|46941|47825|

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Connecticut Department of Public Health. (2009). *Asthma data fact sheet for the five largest cities in Connecticut.*

Connecticut Department of Public Health. (2011). *Mortality statistics.* Retrieved from http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598&dphNav_GID=1601&dphNav_GID=1601

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APPENDIX B: Household Telephone Study Statistical Considerations

The Household Telephone Study sampling strategy was designed to represent Waterbury and its surrounding towns. The sampling strategy identified the number of completed surveys needed within each ZIP code based on the population statistics from the U.S. Census Bureau in order to accurately represent the area. Call lists of household land-line telephone numbers were created based on the sampling strategy. The final sample (1,121) yields an overall error rate of +/-2.9% at a 95% confidence level. This means that if one were to survey all residents of Waterbury, the final results of that analysis would be within +/-2.9% of what is displayed in the current data set.

Data collected from the 1,121 respondents was aggregated and analyzed by Holleran using IBM SPSS Statistics. The detailed survey report includes the frequency of responses for each survey question. In addition, BRFSS results for Connecticut and the United States are included when available to indicate how the health status of Waterbury residents compares on a state and national level. All comparisons represent 2011 BRFSS data unless otherwise noted. It is important to note a few questions on the survey did not have comparisons to Connecticut and/or national data because of survey modifications.

It is common practice in survey research to statistically weight data sets to adjust for demographic imbalances. For example, in the current household survey, the number of females interviewed is above the actual proportion of females in the area. The data was statistically weighted to correct for this over-representation of females. It should be noted that the national dataset (from the CDC) is also statistically weighted to account for similar imbalances.

APPENDIX C: Household Telephone Study Participant Demographics

Gender and Age

Demographic Category		Waterbury CT 2013 BRFSS (n = 743)	Surrounding Towns 2013 BRFSS (n = 378)
Gender	Male	36.7%	35.4%
	Female	63.3%	64.6%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 735)**	**Surrounding Towns 2013 BRFSS (n = 374)**
Age Group	18 - 24	2.9%	4.8%
	25 - 34	9.0%	5.3%
	35 - 44	10.2%	12.8%
	45 - 54	17.0%	22.7%
	55 - 64	24.4%	21.7%
	65 years and over	36.6%	32.6%

Race and Ethnicity

Demographic Category		Waterbury CT 2013 BRFSS (n = 737)	Surrounding Towns 2013 BRFSS (n = 378)
Hispanic/Latino	Yes	13.0%	2.6%
	No	87.0%	97.4%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 715)**	**Surrounding Towns 2013 BRFSS (n = 377)**
Race	White	73.6%	94.4%
	Black or African American	16.5%	0.8%
	Asian	1.8%	1.6%
	Native Hawaiian or Other Pacific Islander	0.4%	0.0%
	American Indian or Alaska Native	1.4%	0.5%
	Other	6.3%	2.7%

Marital Status and Children

Demographic Category		Waterbury CT 2013 BRFSS (n = 734)	Surrounding Towns 2013 BRFSS (n = 376)
Marital Status	Married	36.2%	58.0%
	Divorced	16.9%	13.0%
	Widowed	17.8%	13.8%
	Separated	3.0%	0.8%
	Never Married	22.9%	12.5%
	Member of an unmarried household	3.1%	1.9%
Demographic Category		**Waterbury CT 2013 BRFSS (n = 742)**	**Surrounding Towns 2013 BRFSS (n = 378)**
Number of Children in Household	None	74.5%	70.9%
	One	12.3%	14.3%
	Two	8.1%	12.2%
	Three	3.2%	2.4%
	Four	1.1%	0.0%
	Five	0.7%	0.3%
	Six	0.1%	0.0%

Educational Attainment

Demographic Category		Waterbury CT 2013 BRFSS (n = 739)	Surrounding Towns 2013 BRFSS (n = 376)
Education Level	Never attended school or only attended kindergarten	0.4%	0.5%
	Grades 1 through 8	3.7%	2.1%
	Grades 9 through 11	6.5%	2.1%
	Grade 12 or GED	31.9%	20.7%
	College 1 year to 3 years	31.8%	27.1%
	College 4 years or more	25.7%	47.3%

Employment Status

Demographic Category		Waterbury CT 2013 BRFSS (n = 741)	Surrounding Towns 2013 BRFSS (n = 376)
Employment Status	Employed for wages,	38.9%	49.2%
	Self-employed,	3.6%	10.1%
	Out of work for more than 1 year,	4.3%	2.7%
	Out of work for less than 1 year,	2.8%	1.6%
	Homemaker,	3.5%	3.2%
	Student,	1.3%	1.9%
	Retired, or	34.5%	26.9%
	Unable to work	10.9%	4.5%

Income

Demographic Category		Waterbury CT 2013 BRFSS (n = 574)	Surrounding Towns 2013 BRFSS (n = 301)
Income	Under $10,000	8.4%	2.0%
	$10,000 to less than $15,000	13.2%	5.3%
	$15,000 to less than $20,000	6.6%	2.3%
	$20,000 to less than $25,000	10.8%	4.3%
	$25,000 to less than 35,000	14.5%	8.3%
	$35,000 to less than 50,000	14.1%	12.6%
	$50,000 to less than 75,000	14.6%	17.9%
	$75,000 or more	17.8%	47.2%

APPENDIX D: Key Informant Participants

Name	Title	Organization
Tina Agati	Executive Director	Literacy Volunteers of Greater Waterbury
Eric Albert	President	Albert Brothers, Inc.
Michele A. Albini	Constituent Service Aide	City of Waterbury
Janine Altamirano	Program Coordinator	Waterbury Department of Public Health
Maryangela Amendola	Director	Chase Family Resource Center
Joel Becker	President & Chief Executive Officer	Torrco
Carolann Belforti	JobLinks Coordinator	Northwest Regional Workforce Investment Board
Michelle Bettigole	Executive Director	The Watermark at East Hill
Christine Bianchi, MSW, LCSW	Chief Developmental Officer	Staywell Health Care, Inc.
O. Joseph Bizzozero, MD	Administration	Alliance Medical Group
Charles Boulier	President & Chief Executive Officer	Naugatuck Savings Bank
Samuel Bowens	HIV Prevention Coordinator	Waterbury Health Department
Betty Bozzuto	Chief Nursing Officer,	Saint Mary's Hospital
Ellen Brotherton	Assistant Director	Western CT Mental Health Network - Waterbury
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Katherine Carten	Parish Administrator	Saint Michael's Parish, Naugatuck
Ellen Carter	Program Officer	Connecticut Community Foundation
Kathy Case	Director of Program Management	Waterbury ARC
Julie Clark	Wellness Environmental Lifestyle Consultant	
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Meghan Cleary	Director of Nursing	Wolcott View Manor
Mary Conklin	Housing Attorney	Connecticut Legal Services
Joseph G. Conrad	Program Director	Connecticut Counseling Centers, Inc.
Ronald Conti	Vice President	Heritage Village
Marilyn Cormack	President	BHCare
JoAnne Cosgriff, MD	Director, Performance Improvement	Waterbury Hospital
Janice Crelan	Assistant Treasurer	Hubbard-Hall, Inc.
Kelly Cronin	Executive Director	Waterbury Youth Services
Andrea Cuff, APRN		Chase Outpatient
Jerome Dais	Elder	Family Worship Center
Kristen Davila	Director	Morris Senior Center
Nancy Deming	Director	VNA Northwest
Catherine R. Dinsmore	Senior Center Director	Falls Avenue Senior Center
Deborah Duarte	Missions President	Community Tabernacle Outreach Center
Richard Dumont	Community Resident	
Kris Durante	Coordinator	Bridge To Success
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Tim Epperson	Food Pantry Coordinator	Greater Waterbury Interfaith Ministries
Michelle Fica	Managing Attorney	Connecticut Legal Services
Bethany Ann Fickes	Office Assistant	Saint Mary's Hospital
Christina Fishbein	Executive Director	Western Connecticut Area Agency on Aging
Ron Flormann	Chief Commercial Officer	Glenwood Systems, LLC
Natalie Forbes	Grant Coordinator	Waterbury Hospital
Auguste Fortin, VI, MD	Physician	Yale Primary Care Residency Program/ Waterbury Hospital
Yvette Highsmith Francis	Regional Director	Community Health Center, Inc.
Todd Gaertner	Nursing Home Administrator	Lutheran Home of Southbury

Sarah Geary	Constituent Services Manager	City of Waterbury
Sharon Gesek	Director of Elderly Services	Town of Southbury
Bill Gibbs	Owner	Bill Gibbs Massage Therapy
Mary-Kate Gill	Director of Elder Services	New Opportunities, Inc.
Jackie Giordano, RN	Nurse	Saint Mary's Hospital
Michelle Godin	Director	Saint Mary's Hospital
Joe Gorman	Supervisor of Health & Physical Education	Waterbury Board of Education
Lydia Granitto	Membership & Marketing Manager	Girl Scouts of Connecticut
Bernadette Graziosa	President	The Grotto Restaurant & Mrs. G's Gift Baskets
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Joy Hall	Director	Salvation Army
Lori Hart	Director	Bridge To Success
Robyn Hawley	Director of Behavioral Health	Catholic Charities Archdiocese of Hartford
Eileen Healy	Executive Director	Independence Northwest, Inc.
Tina Herman	Assistant Director of Critical Care	Waterbury Hospital
Arlene G. Herrick	Property Manager	Grace Meadows Elderly Housing
Chris Hibbs	Health & Wellness Director	Greater Waterbury YMCA
Stephen Holt	Assistant Professor	Yale Primary Care Residency
Geralyn Hoyt	Chief	Southbury Ambulance
Lucia Hughes	Manager	Waterbury Hospital
Stephen Huot, MD	Director	Yale Primary Care Residency Program/ Waterbury Hospital
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Eric Hyson, MD	Attending Physician	Waterbury Hospital
Sandi Iadarola	Chief Nursing Officer	Waterbury Hospital
Azhar Imam, MD	Chief of Psychiatry	Saint Mary's Hospital
Kristen Jacoby, MPH	President/Chief Professional Officer	United Way of Greater Waterbury
Donna Johnson	Community Relations Liaison	Diagnostic Radiology Associates
Mark Johnson, LMFT	Program Director	Wellspring Foundation
Jan Kennedy	Executive Director	Cardiology Associates of Greater Waterbury, LLC
Elizabeth Korn, APRN	Nurse	Saint Mary's Hospital
Lisa Labonte	SNS Director	New Opportunities, Inc.
Leo Lavallee	Principal	Waterbury Arts Magnet School
Stephen Lewis	Chief Executive Officer/President	Thomaston Savings Bank
The Rev. Jeanne Lloyd	Minister	Mattatuck Unitarian Universalist Society
Ben Loveland	Assistant Director	Waterbury Hospital
Vanessa Lucewicz	Practice Manager	Franklin Medical Group
Frederick Luedke	Chairman, Board of Greater Waterbury Health Network Inc.	Waterbury Hospital
Neal Lustig	Director of Health	Pomperaug Health District
Robin Marino	Clinical Manager	Saint Mary's Hospital
Judith Martin	Program Coordinator	Child & Adolescent Behavioral Health
Kate Mattias	Executive Director	National Alliance on Mental Illness Connecticut
Bahar Matusik	Clinical Pharmacy Manager	Waterbury Hospital
Jennifer McGarry	Patient Services Manager	Leukemia and Lymphoma Society
Patricia A. McKinley	Strategic Volunteer to Non-Profit Organizations	Waterbury Health Home Coalition; United Way Greater Waterbury; Connecticut Community Foundation
Kathleen McManamy, LCSW	Regional Supervisor	Connecticut Community Care, Inc.
Kathleen McNamara	Community Resident	
Emmett McSweeney	Library Director	Silas Bronson Library
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Chris Miller	Administrative Fellow	Saint Mary's Hospital

Thomas Missett	Chief Development Officer	Waterbury Hospital
Alan C. Mogridge	Executive Director	Valley YMCA
Peg Molina	Director of Social Services	Town of New Milford
Patrick Morgan	Interim Director Surgical Services	Waterbury Hospital
Drew Morten	Physician Assistant	Connecticut Academy of Physician Assistants
Luci Moschella	Nursing Supervisor	Waterbury Health Department
Lois Mulhern	Nursing Supervisor	Waterbury Health Department
Melanie Nachajska, LCSW		YNA Health Care
James O'Rourke	CEO	Waterbury YMCA
Peggy Panagrossi	Executive Director	Safe Haven of Greater Waterbury
Kim Pernerewski	President	National Alliance on Mental Illness Waterbury
Peter Porrello, MD	Physician	Waterbury Hospital
Pamela Pratt	Manager, OP Behavioral Health	Saint Mary's Hospital
Fenn Quigley	Community Resident	
Ernst Racine, Jr.	Family Center Coordinator/Fatherhood Specialist	Catholic Charities
Loryn Ray, MPH	Director of Elderly Services	Town of Woodbury
Pamela Redmond	Public Affairs Officer	VA Connecticut Healthcare System
Thomas E. Reinahrdt, MD	Chief of Psychiatry	Waterbury Hospital
Laurie Reisman	Director of Operations	Family Services of Greater Waterbury, Inc.
JoAnn Reynolds-Balanda	VP Community Impact	Untied Way of Greater Waterbury
Diane Rokosky, R.N		Public Health Deptartment
P. Russell	Community Resident	
William Rybczyk	Director Research, Development, & Planning	New Opportunities, Inc
Linda Sapio-Longo, APRN	Family Nurse Practitioner	Waterbury Hospital Infectious Disease Clinic
John A. Sarlo	Director	Mattatuck Senior Center, Inc.
Donita Semple	Senior Manager, Performance Improvement	Waterbury Hospital
Loraine Shea	Director	Waterbury Hospital
Frank Sherer	Senior Vice President	Timex Group
Carl Sherter, MD	Chief of Staff	Waterbury Hospital
Catherine Sousa	Supervisor of Patient Transport	Saint Mary's Hospital
Linda Spadaccini	Library Director	Waterbury Hospital
Susan Stauffacher	Chairman	Roxbury Council on Aging
Gary Steck	Chief Executive Officer	Wellmore Behavioral Health
Monica Stokes	Assistant Manager Customer Support	Waterbury Hospital
Christine Thomas-Melly	Benefits Manager	Waterbury Hospital
Donald Thompson	Chief Executive Officer	Staywell Health Center
Joseph M. Tuggle, MD	Physician	Complete Newborn Care, PC
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Kara Vendetti	WIC Program Coordinator	Waterbury Health Department-WIC Program
Deborah Vitarelli	Executive Director	Waterbury Arc, Inc.
Kathy Volz	Practice Manager CFHC	Franklin Medical Group at Saint Mary's Hospital
Chad Wable	President & Chief Executive Officer	Saint Mary's Hospital
Julie Weidemier	Assistant Director	Waterbury Hospital
Claude E. Williams	Executive Director	Mount Olive A.M.E. Zion Senior Citizens Center, Inc.
Jeffrey Williams	Grant Writer	Waterbury Hospital
Eileen Woods	Assistant Director Telemetry	Waterbury Hospital
Kathy Woods	Executive Director	Living in Safe Alternatives, Inc.
D. Woolley	VP Human Resources	Waterbury Hospital
Randy York	Infant Immunization Coordinator	Waterbury Health Department
Mary Zasada	Clinical Informatics Manager	Saint Mary's Hospital
Melissa Zwang	Program Director	New Opportunities, Inc.
Patricia Zuccarelli	Director	Department of Children & Families

Appendix E: Prioritization Session Participants

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living
Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

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Special Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.
Boards of Directors
Thursday, June 30, 2014

Present
Robert J. Mazaika, Chair
S. Mark Albini, M.D.
Joseph Carlson (via phone)
Garrett Casey
Rev. Monsignor James Coleman
Stephen R. Griffin, Esq.
Michael Karnasiewicz, M.D.
Sister Dolores Lahr, CSJ
Angela Mattie
Joseph Mengacci, Esq.
Michael O'Brien
Dick Pugh
Robert Roscoe
Jim Smith
Laura St. John
Christine Sullivan, Esq.
James Uberti, M.D.
Chad W. Wable

Staff Present
Robert J. Anthony, Esq.
Ralph Becker
Victoria Cipriano
Joe Connolly
Steve Schneider, M.D.

Invited Guest:
Michael Hammond
Elaine Yao (via phone)

Excused
Eric Albert
Robert Gumbardo, M.D.
Felix Rodriguez

I. Call to Order & Opening Prayer

Upon provision of due notice, the meeting of the Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. Boards of Directors was called to order by the Chairman, Robert J. Mazaika, at 5:30 p.m. with the opening prayer offered by Monsignor J. Coleman.

II. Report of the Chairman

Mr. Mazaika thanked everyone for making time in their busy schedules to attend a Special Board meeting this evening.

Report of the Board Taskforce

Mr. Mazaika advised that today's board meeting will focus on board discussion. He noted that we are not asking the Board to make any decisions at this meeting. He encouraged the Board to ask questions during his report. He also advised that the Board Taskforce members were present to answer any questions. Mr. Mazaika provided an update and recommendation from the Board Taskforce.

Mr. Mazaika provided a presentation that covered the following topics. He provided an overview of the affiliation process. He discussed the background information on Tenet and REDACTED REDACTED He provided a high level comparison of offers between Tenet and Mr. Mazaika advised that the recommendation between the two suitors was based on the Guiding Principles of Affiliation. A discussion was held regarding potential clinically integrated networks in Connecticut. Mr. Mazaika advised that the Board Taskforce recommended Tenet Healthcare. Mr. Maziaka provided a summary of the key terms of the Tenet deal and the approval process. An extensive discussion ensued.

Mr. Mazaika reported that he met with Archbishop Blair. He also reported that Mr. Wable, Mr. Hammond and Attorney Anthony also met with Archbishop Blair to review the Board Taskforce recommendation. Mr. Mazaika reported that he received a letter from Archbishop Blair dated June 23, 2014 receiving approval of the recommendation. Mr. Mazaika also advised that Archbishop Blair will obtain approval from Rome of the acquisition. Mr. Wable advised that we are addressing Archbishop Blair's concerns that are stated in his letter dated June 23, 2014.

Mr. Mazaika advised that the meeting materials discussed at today's Board meeting will be posted to the SMHS Board Portal. Mr. Mazaika asked the Board as part of their fiduciary responsibility to review the meeting materials listed below in order for the Board to make an informed decision:

- Letter from Archbishop Blair, June 23, 2014
- H2C PowerPoint Presentation
- Asset Purchase Agreement
- Board Resolutions
- Press Release and Communication Material

He encouraged the Board Members to call with any questions that they may have concerning the Board Taskforce's recommendation. A Special Board Meeting is scheduled for Thursday, July 3, 2014, for final questions and answers and to take action on the Board Taskforce recommendation.

Mr. Mazaika reminded everyone that all of the information presented is confidential. Mr. Wable advised that a press release and communication material will also be posted to the Board Portal and is highly confidential.

III. Announcements/Relevant Readings/Agenda Items

Mr. Mazaika advised that a Special Board Meeting will be held on Thursday, July 3, 2014 at 7:30 a.m. to vote on the recommendation. The next SMHS/SMH Board meeting will be held on August 21, 2014 at 7:00 am. Mr. Wable advised that a relevant reading from Modern Healthcare: "The Big Bulk Up", June 23, 2014, will also be posted to the SMHS Board Portal.

IV. Adjournment

There being no further business, the meeting adjourned at 6:20 p.m.

Respectfully submitted,	Approved by,
Victoria Cipriano Recording Secretary	Robert J. Mazaika Chairman of the Board

Special Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.
Boards of Directors
Thursday, July 3, 2014

Present
Robert J. Mazaika, Chair
S. Mark Albini, M.D.(via phone)
Joseph Carlson (via phone)
Garrett Casey (via phone)
Rev. Monsignor James Coleman
Stephen R. Griffin, Esq.
Michael Karnasiewicz, M.D.
(via phone)
Sister Dolores Lahr, CSJ (via phone)
Angela Mattie (via phone)
Joseph Mengacci, Esq.
Michael O'Brien (via phone)
Dick Pugh (via phone)
Robert Roscoe (via phone)
Jim Smith (via phone)
Laura St. John
Christine Sullivan, Esq.
James Uberti, M.D.
Chad W. Wable

Staff Present
Robert J. Anthony, Esq. (via phone)
Victoria Cipriano
Steve Schneider, M.D.

Invited Guest:
Greg Hammond (via phone)
Michael Hammond (via phone)
Elaine Yao (via phone)
Jerry Sugar, M.D. (via phone)

Excused
Eric Albert
Robert Gumbardo, M.D.
Felix Rodriguez

I. Call to Order & Opening Prayer

Upon provision of due notice, the meeting of the Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. Boards of Directors was called to order by the Chairman, Robert J. Mazaika, at 7:30 a.m. with the opening prayer offered by Monsignor J. Coleman.

II. Report of the Medical Staff

Medical and Affiliate Staff Applicants

Aziz Richi, M.D., reported that the request for Medical Staff appointments and privileges and recommendations of the Credentials Committee were reviewed and approved by the Credentials and the Medical Executive Committee. For further information, please refer to the list attached hereto and made part of these minutes.

Action: Motion was made, seconded, and carried to approve the Medical Staff appointments, request for privileges, as submitted in the meeting materials.

III. Report of the Chairman

Report of the Board Taskforce

Mr. Mazaika questioned the Board whether anyone had questions concerning the June 30, 2014 recommendation of the Board Taskforce. Attorney Anthony advised that the Board Taskforce has unanimously recommended to the Board the sale of Saint Mary's Hospital to Tenet Healthcare. He reported that the Board Taskforce thoroughly investigated all of the options available to them and chose the best option for Saint Mary's. An extensive discussion ensued.

Further discussion ensued regarding employed physicians, ownership percentage among the other parties, federal trade commission, and a review of the current structure and communication plan. Mr. Mazaika advised that Tenet will be the sole purchaser of Saint Mary's Hospital. It is a single owner solution and a separate and distinct transaction from Waterbury Hospital.

Mr. Mazaika presented the Resolutions attached hereto and made a part of these minutes for the Board's review and approval. Attorney Anthony reviewed the Board Resolutions with the Board.

Action: Motion was made, seconded, and carried to approve the Resolution and transaction to sell the assets of Saint Mary's Hospital to Tenet Healthcare Corporation.

Mr. Mazaika thanked the Board Taskforce for all of their efforts and giving up their time during this process. He thanked Mr. Smith for his involvement and his efforts in this process. Mr. Mazaika was very much appreciative of everyone's efforts. Mr. Wable reminded the Board that it is very critical that this information remain confidential. He advised that a press release will be made to the public on Tuesday.

Mr. Carlson raised concern that language was not in the Asset Purchase Agreement giving the option to retain the pension, and the pension would be valued by their Actuary with them assuming the pension. Attorney Anthony noted that the language was to be revised and advised that he will work with Tenet to revise language.

Mr. Wable advised that a Public Hearing will be scheduled before the August 21st Board Meeting.

IV. Announcements/Relevant Readings/Agenda Items

Mr. Mazaika advised that the next SMHS/SMH Board meeting will be held on August 21, 2014 at 7:00 am.

V. Adjournment

There being no further business, the meeting adjourned at 7:55 a.m.

Respectfully submitted,	Approved by,
Victoria Cipriano Recording Secretary	Robert J. Mazaika Chairman of the Board

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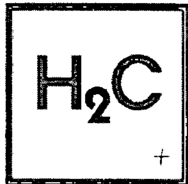

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Affiliation Timeline

2002

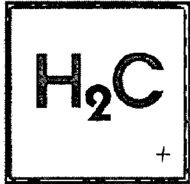
- In 2002, Saint Mary's Health System ("Saint Mary's or "SMHS") had multiple years of operating losses that missed budgeted levels for performance
- SMHS was nearing technical default on its bonds because SMHS' poor operating performance led to weakened debt and liquidity ratio measures
- SMHS installed a new management team and began a Performance Improvement Plan to plan for the future of SMHS as a stand-alone entity

2003 – May 2006

- In December 2003, after evaluating SMHS' viability as a stand-alone organization, the SMHS Board adopted an Affiliation Strategy as part of its Strategic Plan
- In May 2004, the SMHS Board appointed its first Affiliation Task Force
- In December 2004, the Affiliation Workgroup was formed to explore a possible affiliation between SMHS and Waterbury Hospital ("Waterbury")
- In 2005 and 2006, SMHS was in default of its bond covenants

June 2006 – January 2007

- The Chartis Group created a financial forecast for SMHS and Waterbury as a combined entity. Active discussions occurred regarding a local affiliation option with Waterbury
- SMHS decided to pursue regional and national affiliation options
- SMHS, along with its advisor, Shattuck Hammond Partners, created a Confidential Information Memorandum ("CIM") to distribute to potential partners



Affiliation Timeline (cont'd)

June 2006 – January 2007 (cont'd)

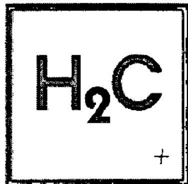
- In December 2006, Shattuck Hammond distributed the CIM to eight national and local healthcare systems and not-for-profit hospitals (six of the eight were Catholic healthcare systems):
- There were no viable proposals due to the economic environment, SMHS' recent performance at the time and SMHS' large unfunded pension liability and debt balance

February 2007 – July 2009

- SMHS continued discussions with Waterbury
- SMHS and Waterbury, with the assistance of Morgan Keegan (acquirer of Shattuck Hammond) and Kaufman Hall, discussed the terms and conditions of a proposed merger
- Ultimately, SMHS and Waterbury were not able to reach suitable terms
- SMHS focused on growing and improving its operations and profitability
- In 2009, SMHS initiated a new strategic planning process with its Board
  - SMHS developed a consolidated five-year strategic capital plan and set operational and financial targets
  - SMHS studied its ability to (1) remain independent as a stand-alone entity while continuing to meet the healthcare needs of the community; (2) adequately fund its pension plan and service its debt; and (3) invest capital in its facilities

August 2009 – October 2009

- SMHS and LHP Hospital Group, Inc. ("LHP") held discussions regarding a potential Joint Venture
- SMHS provided LHP with requested due diligence material



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Affiliation Timeline (cont'd)

August 2009 – October 2009 (cont'd)

- LHP submitted a preliminary offer to form a Joint Venture with SMHS
- SMHS decided to examine options as a stand-alone entity versus affiliating with a partner

November 2009 – April 2010

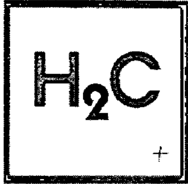
- SMHS developed a strategic plan that addressed future plans as a stand-alone entity while still considering affiliation options primarily to address its future financial sustainability and access to capital
- SMHS concluded that it needed a capital partner

May 2010

- SMHS formed another Affiliation Task Force to embark on a process to affiliate with a strategic partner
- Morgan Keegan developed a strategy to market SMHS to strategic partners and identify the most likely potential partners

June 2010

- In conjunction with Management, Morgan Keegan drafted an updated CIM that described SMHS and the opportunities SMHS could provide to prospective strategic partners



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Affiliation Timeline (cont'd)

July 2010

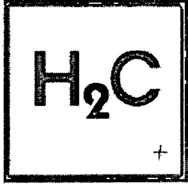
- Morgan Keegan contacted nineteen potential strategic partners:
  - 16 parties signed Confidentiality Agreements and received the CIM
  - Of the 16 parties who received the CIM, six interested parties provided initial Indications of Interest
    - Five parties submitted Asset Purchase or Joint Venture proposals
    - One party submitted a Services Agreement Proposal with no numerical values proposed
    - One of the parties who submitted and Asset Purchase proposal subsequently removed itself from the process
    - The initial Indications of Interests provided an Implied Enterprise Value range of $70.5 – $190.4 million

August 2010 – September 2010

- SMHS had Management Meetings with four parties
- Morgan Keegan and SMHS also participated in site visits at three locations

October 2010

- The four parties were asked to submit best and final offers
  - The final Indications of Interests provided an Implied Enterprise Value range of $125.9 – $196.0 million
- On October 19, 2010, a fifth entity, a national faith-based not-for-profit, in conjunction with a private equity firm, submitted an Indication of Interest with an Implied Enterprise Value range of $104.1 - $115.6 million
- In conjunction with Management, Morgan Keegan reviewed the Indications of Interest and presented the findings to the Board



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Affiliation Timeline (cont'd)

November 2010

- On November 10, 2010 SMHS entered into negotiations and due diligence with one of the interest parties

December 2010

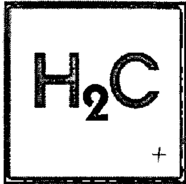
- SMHS and the aforementioned party were unable to come to agreement in negotiating the terms and conditions of a Definitive Agreement and terminated discussions

January 2011 – March 2011

- SMHS and Morgan Keegan contacted the remaining parties and held conference calls to provide market and performance updates and to address any questions or concerns
- SMHS received updated LOIs/proposals from two parties
- The Taskforce met on January 4th to review proposals and selected a preferred partner
- On January 13, 2011 SHMS entered into a Letter of Intent with LHP
- SMHS and LHP performed an extensive due diligence review
- SMHS and LHP finalized the Definitive Agreement, pending governmental approval, in March 2011

April 2011 - July 2011

- SMHS and LHP worked on a Certificate of Need application for approval of a Joint Venture and submitted its filing on July 21, 2011



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Affiliation Timeline (cont'd)

August 2011 – August 2012

- SMHS and LHP began discussions with Waterbury to potentially include them in the Joint Venture
- Waterbury agreed to become part of a three-way Joint Venture
- LHP terminated discussions with SMHS regarding the joint venture with SMHS and Waterbury Hospital

September 2012 – March 2013

- SMHS began discussions with the national faith-based not-for-profit, in conjunction with a private equity firm party
- The aforementioned party submitted a Letter of Intent on October 29, 2012 for a cash purchase price ranging from $115 million to $135 million plus assumption of the pension liability
- The aforementioned party performed extensive due diligence on SMHS and submitted several revisions to its Letter of Intent
  - On March 20, 2013, the aforementioned party submitted the final revision to its Letter of Intent which eliminated the cash purchase price and included the assumption of the pension liability
- Ultimately, SMHS and the aforementioned party were unable to reach agreement on key terms

March 2013 – April 2013

- During Spring 2013 Hammond Hanlon Camp LLC (a newly formed firm founded by the key individuals advising SMHS from Morgan Keegan) contacted the following six organizations who signed confidentiality agreements with SMHS and were granted initial access to the data room
- One of the parties terminated discussions with SMHS due to their strategic focus on other markets outside of Waterbury

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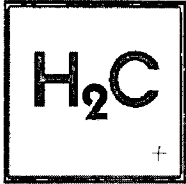

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Affiliation Timeline (cont'd)

March 2013 – April 2013 (cont'd)

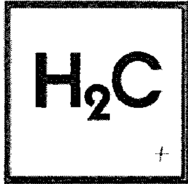
- A second party ("Party 2") wanted to delay commencing discussions due to their focus on closing an unrelated affiliation
- H2C sent transmittal letters to three organizations:
- H2C also contacted two additional parties, but they did not express an interest in SMHS

May 2013 – June 2013

- Three parties submitted non-binding Indications of Interest
  - One of the parties submitted a revised non-binding Indication of Interest
  - One of the parties bids was well below the other two offers
- Party 2 had a meeting with Saint Mary's
- SMHS had a meeting with an additional potential partner, a not-for-profit Catholic hospital ("Party 3")

June 2013 – September 2013 (cont'd)

- The two parties who submitted Indications of Interest with the highest offers were invited to participate in Round 2 of the process
- Both parties performed due diligence on Saint Mary's including week-long site visits
- In August 2012, one of the parties withdrew interest in SMHS due to its concerns regarding the healthcare landscape in Connecticut
- On September 5th, Vanguard submitted a revised non-binding indication of interest for SMHS with a $150 million purchase price
- On September 20th, Vanguard met with the Taskforce to discuss its latest offer and its process with SMHS going forward



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Affiliation Timeline (cont'd)

October 2013 – April 2014

- SMHS and Tenet Healthcare (formerly Vanguard) continued negotiating the final terms of the asset purchase agreement
- Party 2 and SMHS reengaged in discussions
- Both Party 2 and Tenet met with the Taskforce to express their interest in SMHS

May 2014 – Present

- SMHS and Party 2 continued negotiating the final terms of the affiliation agreement
- SMHS and Tenet continued negotiating the final terms of the asset purchase agreement
- The Taskforce selected Tenet as its preferred partner in June
- Party 3 requested a meeting with SMHS to discuss a potential opportunity with a national catholic healthcare system and itself

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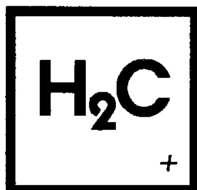

Tenet Healthcare Corporation

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Location: Dallas, TX
Rating: B1/B/B

Company Description

- Tenet Healthcare operates 78 acute care hospitals, including four academic medical centers, with 20,279 licensed beds in 14 states
  - Three hospitals in Massachusetts and two hospitals in Pennsylvania
- Tenet also operates 190 free-standing provider-based outpatient centers in 16 states, including diagnostic imaging centers, ambulatory surgery centers, urgent care centers, and satellite emergency departments, among others. The Company administers six health plans and seven accountable care organizations, and five clinically integrated organizations
- Tenet provides clinical research programs related to cardiovascular disease, pulmonary disease, musculoskeletal disorders, neurological disorders, genitourinary disease, and other various cancers
- Outside of hospital operations, the Company also owns Conifer Health Solutions LLC, which provides business process solutions to more than 700 hospital and other related clients nationwide
- Tenet was founded in 1967

Hospital Leadership

CEO and President	Trevor Fetter
CFO	Daniel J. Cancelmi
President of Hospital Operations	Britt T. Reynolds
Vice Chairman	Keith Pitts
SVP, Development	Trip Pilgrim

Sources: CapIQ; Company website; Company financials

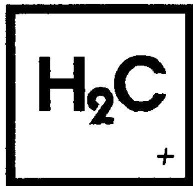
Financial Overview, as of LTM 6/30/14 *($ millions)*

	2012A	2013A	LTM	2014E	2015E
Revenue	$9,119	$11,102	$14,261	$16,999	$17,910
EBITDA	$1,199	$1,342	$1,579	$1,899	$2,147
EBITDA Margin	13.1%	12.1%	11.1%	11.2%	12.0%
EPS	$1.93	$1.70	$1.33	$1.33	$2.75
EV/Revenue	0.92x	1.06x	1.27x	1.01x	0.96x
EV/EBITDA	7.1x	8.2x	10.9x	9.0x	8.0x

Price as of 8/7/2014	$	56.97	Equity Value ($mm)	$5,578
52-Week High	$	58.03	Enterprise Value ($mm)	$17,163
52-Week Low	$	36.87		

Recent Developments

- 6/14 – Tenet acquired a majority interest in Texas Regional Medical Center at Sunnyvale.
- 3/14 – Tenet and Yale New Haven Health System announced a partnership for a comprehensive delivery network in Connecticut
- 8/13 – Tenet and Yale New-Haven Health Systems announced a letter of intent to acquire Eastern Connecticut Health Network
- 6/13 – Tenet acquired Vanguard Health Systems, which significantly increased Tenet's scale and services offered
- 11/12 – Vanguard Health Systems and Bristol Hospital announced that it had signed a letter of intent to be acquired by Vanguard
- 11/12 – Vanguard Health Systems announced it had signed a letter of intent to develop a Joint Venture with the Greater Waterbury Health Network



Tenet's Catholic Hospital Experience

- Tenet believes the historic religious mission of a hospital is a vital part of its identity and an integral part of the hospital's commitment to meeting the needs of the community it serves
- Tenet has been able to help preserve the culture and religious missions of Catholic and other faith-based hospitals, while also making specific commitments regarding ethical and religious directives and charity care
- Tenet hospitals with a Catholic identity adhering to the Ethical and Religious Directives for Catholic Health Care Services include:
  - Saint Francis Hospital, Memphis, Tennessee
  - Saint Louis University Hospital, St. Louis, Missouri
  - St. Mary's Medical Center, West Palm Beach, Florida
  - Saint Vincent Hospital, Worcester, Massachusetts
- The following examples show how Tenet hospitals honor Catholic traditions and mission:

St. Mary's Medical Center

- St. Mary's Medical Center, previously sponsored by the Franciscan Sisters of Allegany, is a 463-bed safety net hospital with strong women's services, pediatrics, oncology, and neuroscience services and became part of Tenet in 2001
  - St. Mary's treats the largest number of charity and Medicaid patients of any hospital in the county
- A Franciscan Sister sits on the hospital board, and the Franciscan tradition is honored at the hospital
- Tenet added crucifixes in each patient room and also placed large crosses at the building entrances
- St. Mary's provides an Annual Report to the Bishop

Saint Vincent Hospital

- Saint Vincent Hospital, founded by the Sisters of Providence, is a 321-bed state-of-the-art hospital, offering sophisticated tertiary services to Worcester and the surrounding community
- Tenet has continued the Catholic tradition, honoring the ERDs and offering chaplaincy services
  - Rev. Msgr. Peter Beaulieu, Director of Mission Integration at the hospital, has served the hospital since 1997 and oversees the chaplaincy program as well as serving on the hospital Board of Trustees, as do the Bishop and the Vicar General of the Diocese of Worcester
  - Chaplains are available around the clock and Mass is offered daily in the Lady of Providence Chapel

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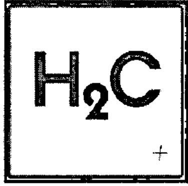
High Level Comparison of Offers

Category	Tenet	Party 2
Type	▪ Asset Purchase	▪ Membership Substitution
Financial	▪ $150 million subject to adjustments referenced in the Asset Purchase Agreement	▪ Assumption of all assets and liabilities

Governance	▪ Local Advisory Board with defined powers
	▪ Powers reserved to Local Advisory Board (during the first 5 years, the following actions require approval by majority vote of the Local Advisory Board):
	  ▪ Merger, dissolution, consolidation, sale or other disposition of the New SM Hospital, unless to an Affiliate of Tenet or to a buyer currently operating similar facilities in the Connecticut
	  ▪ Ceasing operation of the New SM Hospital
	▪ Tenet shall consult with Local Advisory Board regarding:
	  ▪ Development/changes to New SM Hospital strategic plan
	  ▪ New SM Hospital operation/capital budget
	  ▪ Appointment/removal of New SM Hospital CEO
		▪ Party 2 System Board: [Hospitals A/B] (6), [Hospital C] (6), SMHS (3)
		▪ Current SMHS Board remains the same
		▪ Key powers reserved to the SMHS Board:
		  ▪ Amendment of the certificate of incorporation of SMHS;
		  ▪ The closure of Saint Mary's Hospital;
		  ▪ Amendment of the bylaws or operating agreement of any SMH Subsidiary;
		  ▪ The sale, lease, exchange or other disposition of all or substantially all of the property or assets of SMH
		  ▪ Merger or consolidation of SMHS with another corporation; and the reorganization, liquidation or dissolution of SMHS;
		  ▪ Creation of any committee which shall have the authority to act on behalf of the SMHS Board;
		  ▪ Approval of the SMHS strategic plan (first 2 years);
		  ▪ Approval of any commencement, cessation, location, relocation or consolidation of significant clinical services (first 2 years);
		  ▪ Approval of the SMHS capital and operating budgets (first 2 years);
		▪ Supermajority Vote Required: certain board actions exclusively related to SMHS shall require a "Supermajority Vote" of the Party 2 Board meaning 2/3 of the Party 2 Board

Capital Expenditures	▪ Total of $85 million over 7 years for the greater Waterbury market	▪ Party 2 shall make a minimum capital commitment for SMHS of $20 million per year for a 5-year period for a total capital commitment of $100 million
ERDs/Catholic Identity	▪ Tenet will adhere to the ERDs and maintain Catholic Identity at New SM Hospital	▪ Party 2 will adhere to the ERDs and maintain Catholic Identity at SMHS



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Guiding Principles of Affiliation

Principles

Philosophical:

1) Fulfill our community-based Mission

2) Improve the delivery of quality care

3) Adhere to Ethical and Religious Directives and secure our Catholic Identity

4) Maintain local governance and provide locally-based healthcare as part of a regional or national healthcare delivery system

5) Enhance our current position as a charitable health system and hospital while being open to all possible structures to best serve the interest of Saint Mary's and our community

Financial:

1) Improve the net asset value of Saint Mary's

2) Improve access to and cost of capital

3) Fully satisfy unfunded pension liability

4) Improve opportunities to reduce costs by creating efficiencies and economies of scale

5) Improve revenue cycle opportunities

Strategic Position:

1) Acquire the necessary capital to sufficiently address our strategic capital needs

2) Increase market share and improve market position

3) Improve technology and the overall standard of care

4) Provide regional and/or national scale, leverage and resources to address Health Reform requirements

5) Improve future opportunity to regionalize and rationalize the Waterbury healthcare delivery system

People:

1) Improve our ability to meet our obligations to our staff

2) Improve recruitment and retention of talent

3) Create opportunities to strengthen partnerships with the Medical Staff

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Comparison of Offers

Category	Tenet	Party 2
Type	▪ Asset Purchase	▪ Merger or Membership Substitution
Buyer	▪ VHS Saint Mary's Health System, LLC [TBD]	▪ Party 2
Price	▪ $150 million subject to adjustments as referenced in the Asset Purchase Agreement	▪ None
Governance	▪ Local Advisory Board will consist of the Archbishop or his designee ex-officio and a maximum of 10 additional members, at least 5 shall be appointed by the Foundation, 2 shall be local physicians and the remaining members appointed by Buyer's Board of Directors ▪ Local Advisory Board shall be responsible for: ▪ Developing and providing recommendations concerning New SM Hospital's vision, mission and values statement; New SM Hospital's strategic plan; and operating and capital budgets for New SM Hospital; ▪ Providing recommendations concerning the selection of, and providing periodic evaluations of, the Hospital's CEO (with authority over New SM Hospital); ▪ Monitoring operating performance of New SM Hospital; ▪ Monitoring performance improvement initiatives at New SM Hospital; ▪ Granting medical staff privileges and taking disciplinary action consistent with the medical staff bylaws;	▪ SMHS and/or SMH Board Composition: The current SMHS and/or SMH Board membership shall be retained after the closing plus Party 2 shall appoint two (2) individuals who shall serve on the SMHS and/or SMH Board. One of the two individuals appointed by Party 2 will be the President & CEO of Party 2 and one will be a Party 2 Board member. ▪ The terms of the board members will be "re-set" prior to closing with a staggering based on 3-year terms. Board members would be subject to regular board term limits, which is three terms of three years each. The Party 2 Board would have the ability to appoint or remove members pursuant to the bylaws. ▪ **Party 2 Board Composition:** ▪ The Party 2 board would continue to consist of eighteen (18) members. ▪ Number of Designated Board Seats: Party 2 would designate three (3) Party 2 board seats to SMHS: ▪ Hospital A/Hospital B: 9 ▪ Hospital C: 6 ▪ SMHS: 3

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Comparison of Offers

Category	Tenet	Party 2
Governance (cont'd)	▪ Local Advisory Board shall be responsible for (cont'd): ▪ Assuring the quality of medical care and medical staff compliance with applicable accreditation requirements; ▪ Supporting physician recruitment efforts; and ▪ Fostering community relationships and identifying service and education opportunities ▪ Local Advisory Board shall have a standing committee known as the Mission Integration Committee which shall be comprised of not less than 3 members and shall be responsible for oversight of the integration of mission and core values in to the New SM Hospital activities, including the New SM Hospital services and benefits to the community in conformance to the ERDs ▪ Powers Reserved to Local Advisory Board (during the first 5 years, the following actions require approval by majority vote of the Local Advisory Board): ▪ Merger, dissolution, consolidation, sale or other disposition of the New SM Hospital, unless to an Affiliate of Buyer or to a buyer currently operating similar facilities in the State of Connecticut;	▪ **Party 2 Board Composition (cont'd):** ▪ Officers: Party 2 has made a commitment for the Chair position for the next 4 years. After such time, the Chair will be selected by the Party 2 Governance Committee and Board members based on qualifications. ▪ Geographic Composition of the Board: Party 2 shall ensure that there is appropriate representation of the geographic area served by SMHS on the Party 2 board. ▪ Board Members who are not appointed to the Party 2 Board serving on Board subcommittees and subsidiaries: To the extent possible and qualified, current SMHS and/or SMH Board members who are not appointed to the Party 2 Board will be provided an opportunity to serve on a Party 2 Board committee or on the board of a Party 2 subsidiary. ▪ **Supermajority Vote Required:** ▪ Certain board actions on matters exclusively related to SMHS and its subsidiaries shall require a "Supermajority Vote" of the Party 2 board. Until the closing of an affiliation or similar transaction with Hospital D, a Supermajority Vote shall mean the affirmative vote of two-thirds of the members of the Party 2 board. After the closing of an affiliation or similar transaction with Hospital D, a Supermajority Vote shall mean the affirmative vote of two-thirds of the members of the Party 2 board, with the affirmative vote of at least one of the Hospital C directors.

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Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **Supermajority Actions:** ▪ The actions referenced will require a Supermajority Vote except that, subject to the terms of an employment agreement with the CEO, a Supermajority Vote would be required for hiring or termination of the SMHS CEO until the one year anniversary of the affiliation. After the one year anniversary, the President & CEO will have the unilateral authority to hire or terminate the SMHS CEO. ▪ The supermajority voting requirements may be modified by the affirmative vote of 2/3 of the Party 2 board, with the affirmative vote of at least one of th Hospital C directors and will sunset as set forth in the existing Party 2 Bylaws. ▪ **Hospital Responsibilities:** ▪ The management and Board of SMH will continue to operate and manage its facilities, programs and services, including the following but subject to the reserved powers of Party 2 as the sole member: ▪ Review local quality and service goals and improvement programs within the context of the System's goals and programs and recommend changes to the Party 2 Board; ▪ Monitor local quality, service and financial performance of the System; ▪ Approve medical staff bylaws and medical staff appointments based on standardized System applications and review processes; ▪ Participate in the search process for the CEO of SMHS when the need arises;

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Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **Hospital Responsibilities:** ▪ Support management in making local communications with external audiences, including, but not limited to, local governments and the media; ▪ Support fundraising efforts conducted by the Saint Mary's Hospital Foundation in the local community; ▪ Oversee community benefit programs in the local community; and ▪ Such other responsibilities as may be set forth in a definitive agreement. ▪ **Years 1 and 2 – Dual Authority – SMH and Party 2 - the following actions require approval by the Boards of both SMH and Party 2:** ▪ Amendment of the certificate of incorporation of SMH or any SMH Subsidiary; ▪ The election and removal of a director of a SMH Subsidiary; ▪ The election of the officers of SMH; ▪ The closure of St. Mary's Hospital; ▪ Amendment of the bylaws or operating agreement of any SMH Subsidiary; ▪ The sale, lease, exchange or other disposition of all or substantially all of the property or assets of SMH or any SMH Subsidiary; ▪ Approval of the creation of any corporation of which SMH or an SMH Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of SMH or any SMH Subsidiary with another corporation; and the reorganization, liquidation or dissolution of SMH or any SMH Subsidiary;

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Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **Years 1 and 2 – Dual Authority – SMH and Party 2 - the following actions require approval by the Boards of both SMH and Party 2 (cont'd):** ▪ Approval of loans by SMH or any SMH Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds an amount designated by Party 2 or which has a term longer than one year; ▪ Creation of any committee which shall have the authority to act on behalf of the SMH Board or on behalf of any SMH Subsidiary; ▪ Approval of any conveyance of, or the granting of mortgages or trusts on any real property assets of SMH or of any SMH Subsidiary; ▪ Approval of any change to any employee pension or other employee benefit plans of SMH or any SMH Subsidiary; ▪ Approval of the adoption of or amendment to the policies and procedures governing: (a) indemnification of directors and officers of SMH or any SMH Subsidiary; (b) conflicts or dualities of interest; (c) accounting and investment standards and practices; and (d) such other policies as the Member may from time to time determine; and ▪ Approval of system-wide quality, performance and credentialing standards and procedures to which SMH or any SMH Subsidiary is expected to adhere. ▪ Approval of the strategic plan of SMH and of any SMH Subsidiary;

000259

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **Years 1 and 2 – Dual Authority – SMH and Party 2 - the following actions require approval by the Boards of both SMH and Party 2 (cont'd):** ▪ Approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by SMH or any SMH Subsidiary and approval of the filing of any application for a certificate of need by SMH or any SMH Subsidiary, except that approval of the SMH Board shall not be required for the filing of a certificate of need in connection with any affiliation, acquisition or similar transaction with Waterbury Hospital and/or its affiliates; ▪ Approval of the capital budget and operating budget of SMH and of any SMH Subsidiary; ▪ Approval of unbudgeted expenditures or any increase in any approved annual operating or capital budget in excess of an amount designated by Party 2; ▪ Approval of any agreement or transaction of SMH or any SMH Subsidiary involving an amount in excess of an amount designated by Party 2 with another individual or entity; and

000260

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **Year 1 and 2 – Dual Authority – SMH and Party 2 - the following actions require approval by the Boards of both SMH and Party 2 (cont'd):** ▪ Approval of the affiliation of SMH or any SMH Subsidiary with any other entity for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control, except that approval of the SMH Board shall not be required for any affiliation, acquisition or similar transaction with Hospital D and/or its affiliates. ▪ **Year 1 and 2 – Party 2 Sole Authority - the following actions during the first two years following the affiliation require of Party 2 only and do not require approval of the SMH Board:** ▪ The amendment of the SMH bylaws; ▪ The election or removal of a SMH director, provided that a SMH director shall not be unreasonably removed in the first two years following the closing of the affiliation; ▪ Approval of the engagement in managed care and other third party payor contracting on behalf of SMH or any SMH Subsidiary; ▪ Approval of regulatory compliance and methodology for physician compensation arrangements; and

000261

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **Year 1 and 2 – Party 2 Sole Authority - the following actions during the first two years following the affiliation require of Party 2 only and do not require approval of the SMH Board (cont'd):** ▪ Approval of policies relating to the control and supervision of the investment of SMH's and any SMH Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of SMH or the SMH Subsidiary. ▪ **After Year 2 – Dual Authority – after the second year the following actions require approval by the Boards of both SMH and Party 2:** ▪ The closure of St. Mary's Hospital; ▪ Amendment of the certificate of incorporation of SMH or any SMH Subsidiary; ▪ Amendment of the bylaws or operating agreement of any SMH Subsidiary; ▪ The sale, lease, exchange or other disposition of all or substantially all of the property or assets of SMH or any SMH Subsidiary; ▪ Approval of the creation of any corporation of which SMH or an SMH Subsidiary is the sole or controlling member or sole or controlling shareholder; the merger or consolidation of SMH or any SMH Subsidiary with another corporation; and the reorganization, liquidation or dissolution of SMH or any SMH Subsidiary; and ▪ Creation of any committee which shall have the authority to act on behalf of the SMH Board or on behalf of any SMH Subsidiary.

000262

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **After Year 2 – Party 2 Sole Authority – after the second year the following actions require approval of Party 2 only and do not require approval of the SMH Board:** ▪ The amendment of the SMH bylaws; ▪ The election or removal of a SMH director; ▪ Approval of the strategic plan of SMH and of any SMH Subsidiary; ▪ Approval of any commencement, cessation, location, relocation or consolidation of significant clinical services provided by SMH or any SMH Subsidiary and approval of the filing of any application for a certificate of need by SMH or any SMH Subsidiary; ▪ Approval of the capital budget and operating budget of SMH and of any SMH Subsidiary; ▪ Approval of unbudgeted expenditures or any increase in any approved annual operating or capital budget in excess of an amount designated by Party 2; ▪ Approval of any agreement or transaction of SMH or any SMH Subsidiary involving an amount in excess of an amount designated by Party 2 with another individual or entity; ▪ Approval of the affiliation of SMH or any SMH Subsidiary with any other entity for the purposes of the joint conduct of business or other purposes, whether in the form of participation in said entity through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control;

000263

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **After Year 2 – Party 2 Sole Authority – after the second year the following actions require approval of Party 2 only and do not require approval of the SMH Board (cont'd):** ▪ Approval of the engagement in managed care and other third party payor contracting on behalf of SMH or any SMH Subsidiary; ▪ Approval of regulatory compliance and methodology for physician compensation arrangements; and ▪ Approval of policies relating to the control and supervision of the investment of SMH's and any SMH Subsidiary's funds, including, but not limited to, those funds and properties which may have been donated, bequeathed or devised, or given in trust for the limited or general use of SMH or the SMH Subsidiary; ▪ The election and removal of a director of a SMH Subsidiary; ▪ The election of the officers of SMH; ▪ Approval of the capital budget and operating budget of SMH and of any SMH Subsidiary; ▪ Approval of loans by SMH or any SMH Subsidiary, or the incurring of any indebtedness, secured or unsecured, which exceeds an amount designated by Party 2 or which has a term longer than one year; ▪ Approval of any conveyance of, or the granting of mortgages or trusts on any real property assets of SMH or of any SMH Subsidiary; ▪ Approval of any change to any employee pension or other employee benefit plans of SMH or any SMH Subsidiary;

000264

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Governance (cont'd)	▪ [Space intentionally left blank]	▪ **After Year 2 – Party 2 Sole Authority – after the second year the following actions require approval of Party 2 only and do not require approval of the SMH Board (cont'd):** ▪ Approval of the adoption of or amendment to the policies and procedures governing: (a) indemnification of directors and officers of SMH or any SMH Subsidiary; (b) conflicts or dualities of interest; (c) accounting and investment standards and practices; and (d) such other policies as the Member may from time to time determine; and ▪ Approval of system-wide quality, performance and credentialing standards and procedures to which SMH or any SMH Subsidiary is expected to adhere. ▪ **Service Line Commitment:** ▪ Any termination of a service line at SMH would require a Supermajority Vote of the Party 2 Board but would not require approval of the SMH Board. Party 2 cannot commit to refraining from termination of any service line at SMH for a period of time. A comprehensive analysis of the areas for growth in service lines, including a market-based analysis, would be conducted by the parties.
Included Liabilities	▪ Pension plan and retiree medical plan	▪ All
Excluded Liabilities	▪ Contracts not assumed by Buyer ▪ Liabilities, obligations, claims, violations of law, Medicare overpayments, environmental, etc. arising prior to closing ▪ Long-term debt	▪ None

000265

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Capital Expenditures	▪ $85mm over seven years for all of Greater Waterbury, CT	▪ Party 2 shall make a minimum capital commitment of $20 million per year for a five (5) year period for a total capital commitment of $100 million, for routine, strategic, and clinical programs and services in SMHS's 18-town service area, in accordance with a Strategic Plan to be developed through a collaborative process between SMHS's senior leadership team and Board, and Party 2's senior leadership team. ▪ The Strategic Plan shall include a comprehensive assessment and formal implementation plan, which shall include, but not be limited to, routine, strategic, clinical, infrastructure/equipment, and IT investments. Based on this strategic plan, the parties will establish a capital budget for SMHS with annual budgeted capital contributions, which includes appropriate investments in routine, strategic, clinical, infrastructure/equipment, and IT investments identified through the collaborative process.
ERDs/Catholic Identity	▪ Buyer will adhere to the ERDs and maintain Catholic Identity at New SM Hospital	▪ Buyer will adhere to the ERDs and maintain Catholic Identity at SMHS
Employees	▪ Buyer shall offer employment to all active employees in good standing subject to satisfactory completion by Buyer's usual and customary hiring practices and with salaries at least equal to those being provided by Seller and with employee benefits similar to employee benefit plans offered to employees at other hospitals operated by subsidiaries of Buyer in similar markets	▪ TBD

000266

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Covenant Not to Compete	▪ Sellers and their affiliates shall not compete directly or indirectly with Tenet or Buyer for 5 years from the Closing Date ▪ Seller and their affiliates may not 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 that offers services in competition with the Facilities, including but not limited to 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, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a 30-mile radius of the Hospital (the "Restricted Area"), without Buyer's prior written consent ▪ Sellers and their Affiliates will not be precluded from participating in activities that promote health care services for residents of the communities historically served by Sellers and their Affiliates through the Hospital, including the following activities: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening 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 competitive with services provided by Tenet and Buyer	▪ TBD

000267

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Indemnification	▪ Liability capped at $15 million (with basket of $750k), survival period of 18 months ▪ Survival period of 7 years for: existence and capacity (4.1 and 5.1), title to the Real Property (4.12), and title to the Purchased Assets (4.13); several other maters until expiration of applicable statute of limitations ▪ Establish indemnity reserve account of $15 million	▪ None
Other	▪ Right of First Opportunity For Sale of Hospital: During the first 5 years, if Buyer proposes to sell the assets of the Hospital or Parent proposes to sell or transfer its membership interest in Buyer to a person that is not an Affiliate of Buyer, the Foundation shall have the right of first opportunity to purchase the assets of the Hospital	▪ Any expansion of Party 2's captive insurance programs would require a careful, in-depth analysis.

000268

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Contingencies at Closing	▪ Governmental approvals ▪ Canonical approvals ▪ Reps and warranties true (or have been waived), no Material Adverse Effect ▪ Receive consents to assignments to certain contracts and leases ▪ Buyer shall not be required to agree to any terms or conditions with respect to (i) obtaining any license or approval required to consummate the transaction or (ii) avoiding any action or proceeding by any third party or governmental entity, to the extent such terms or conditions under (i) or (ii) would result in, would be reasonably likely to result in (a) a Material Adverse Effect on Sellers or (b) Buyer, Parent or any of their Affiliates having to cease, sell or otherwise dispose of any assets or business that is material to Buyer or any of its Affiliates or to the material benefits of the transaction	▪ Governmental approvals ▪ Canonical approvals ▪ Reps and warranties true (or have been waived), no Material Adverse Effect ▪ Receive consents to assignments to certain contracts and leases

000269

Comparison of Offers (cont'd)

Category	Tenet	Party 2
Termination	▪ By mutual consent of Seller and Buyer ▪ By Buyer if any conditions to the obligation of Buyer to consummate the transaction are not satisfied ▪ By Seller, if any conditions to the obligation of Seller to consummate the transaction are not satisfied ▪ By Seller or Buyer if the closing date shall not have taken place on or before a certain date ▪ By Buyer if any of the Facilities is destroyed or damaged by fire, theft, vandalism or any other cause or casualty and as a result thereof any material part of the Facilities in the aggregate is rendered unsuitable for its primary intended use for at least six months	▪ By mutual consent of Seller and Buyer ▪ By Seller or Buyer if the closing date shall not have taken place on or before a certain date ▪ By either party if there is a Material Adverse Event
Termination Fee	▪ If all of the conditions to a party's obligation to consummate the transaction are satisfied, yet that party refuses to close, such party shall pay a termination fee equal to $4.5 million (bilateral)	▪ None specified

000270

H

<u>EXHIBIT H</u>

RESERVED

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

   Print Name: ERIC ALBERT
   Company or Employer: ALBERT BROS., INC
   Title: PRESIDENT

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014**. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__ NO _____ YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
__✓__ NO _____ YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__ NO _____ YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__ NO _____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

8/19/14

Date

Please provide the following information:

Print Name: Eric Albert

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: S. Mark Albini, MD
      Company or Employer: Naugatuck Valley Women's
      Title: Health Specialists

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org by Thursday, August 21, 2014. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      _✓_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      _✓_NO _____YES. If 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 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?

      _✓_NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      _✓_NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____ YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
✓ NO _____ YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____ YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO _____ YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

8-26-14

Date

Please provide the following information:

Print Name: S. Mark Albini

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: Joseph Carlson II
      Company or Employer: Retired
      Title: ____________________

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014**. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Joseph Carlson II

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      __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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      __X__ NO _____ YES. If 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 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?

      __X__ NO _____ YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      __X__ NO _____ YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__X__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.

__X__NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.

__X__NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__X__NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

JC II ______Joseph Carlson II______ ______8/15/2014______

Signature Date

Please provide the following information:

Print Name: ____Joseph Carlson II____

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: Garrett E. Casey
      Company or Employer: Casey Family Funeral Services
      Title: owner

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014. If you have any questions, please call Vicky at (203) 709-6471.**

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Garrett F. Casey

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO ____ YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
✓ NO ____ YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO ____ YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 8/14/14

Signature Date

Please provide the following information:

Print Name: Garrett F. Casey

<u>**Conflict of Interest/Financial Disclosure Form**</u>

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

      Print Name: MSGR. James Coleman
      Company or Employer: Archdiocese of Hartford
      Title:____________________

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org by Thursday, August 21, 2014. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: James Coleman

*****

3. Financial Interests

a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

✓ NO _____YES. If 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 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?

✓ NO _____YES. If YES, please provide details.

____

4. Beneficial and/or Employment Interests

a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO ____ YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.

✓ NO ____ YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.

✓ NO ____ YES. If YES, please provide details.

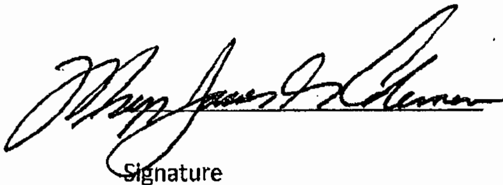
____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO ____ YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

8-20-14

Date

Please provide the following information:

Print Name: MSGR James G. Coleman

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

      Print Name: Joseph Connolly
      Company or Employer: Saint Mary's Health System
      Title: Vice President & Chief Marketing Officer

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org by **Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      _✓_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      _✓_NO _____YES. If 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 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?

      _✓_NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      _✓_NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
__✓__NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature]

Signature

8-26-14

Date

Please provide the following information:

Print Name: Joseph Connolly

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: Joseph Connolly
      Company or Employer: Saint Mary's Health System
      Title: Vice President & Chief Marketing Officer

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014**. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky of any such event or information as soon as possible.

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   a. Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
✓ NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

Joseph Connolly (signature) 8-26-14

Signature Date

Please provide the following information:

Print Name: Joseph Connolly

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

Print Name: CHARLES FLINN
Company or Employer: SAINT MARY'S HEALTH
Title: CHIEF OPERATING OFFICER

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: [handwritten signature]

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__√__NO _____YES. If YES, please provide details.

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c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
__√__NO _____YES. If YES, please provide details.

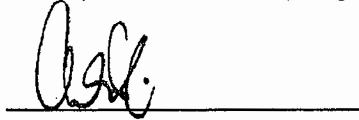
ii. Leased assets to or leased assets from a Tenet Entity.
__√__NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
__√__NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__√__NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



08/25/2014

Signature Date

Please provide the following information:

Print Name: Charles Flynn

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

Print Name: RALPH BECKER
Company or Employer: SAINT MARY'S HOSPITAL
Title: CFO

   b. **Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed** questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Ivan Gecher [handwritten]

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO ____YES. If 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 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?

   ✓ NO ____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO ____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO _____YES. If YES, please provide details.

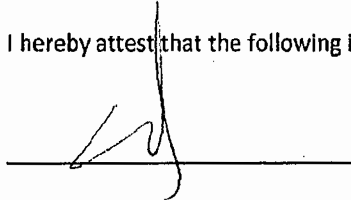
ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

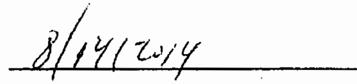
iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.





Signature

Date

Please provide the following information:

Print Name: Anah Archer

000300

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:

   a. Please provide the following information:

   Print Name: PATRICIA A. GERNER
   Company or Employer: THE LAW OFFICE OF PATRICIA A. GERNER, LLC
   Title: PRINCIPAL

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014**. If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: PATRICIA A. GERNER

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      ✓ NO _____YES. If 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 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?

      ✓ NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      ✓ NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
__✓__NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Patricia A. Gerner — August 17, 2014

Signature — Date

Please provide the following information:

Print Name: PATRICIA A. GERNER

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

   Print Name: Stephen R. Griffin
   Company or Employer: Griffin, Griffin + Mays, P.C.
   Title: Board of Directors, Saint Mary's

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Stephen R. Griffin

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      X NO _____YES. If 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 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?

      X NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      X NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet 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.

iii. Been indebted to or loaned money to a Tenet Entity.
X NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

8/15/2014

Signature

Date

Please provide the following information:

Print Name: Stephen R. Griffin

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

      Print Name: ROBERT GUMBARDO, M.D
      Company or Employer: Naugatuck Valley Radiology Associates, P.C.
      Title: PRESIDENT

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org by **Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky of any such event or information as soon as possible.

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   a. Related Person: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Robert Gumbardo, M.D

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      _✓_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      _✓_NO _____YES. If 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 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?

      _✓_NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      _✓_NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
__✓__NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

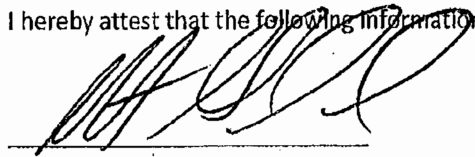
____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.



8/20/14

Signature

Date

Please provide the following information:

Print Name: Robert Gumbardo, M.D

000309

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: Michael Hammond
      Company or Employer: Hammond Harbor Camp LLC
      Title: Principal

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014**. If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      X NO _____YES. If 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 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?

      X NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      X NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

X NO ____ YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
X NO ____ YES. If YES, please provide details.

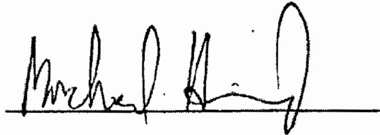
ii. Leased assets to or leased assets from a Tenet Entity.
X NO ____ YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
X NO ____ YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



8-15-14

Signature

Date

Please provide the following information:

Print Name: Michael Hammond

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

Print Name: Laura St John

Company or Employer: VITAS

Title: General Manager of Marketing and Busines Development for CT VITAS

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Laura StJOHN

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
__✓__NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Laura G St John (signature)　　　　8/15/2014

Signature　　　　Date

Please provide the following information:

Print Name: Laura G. St JOHN

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: Michael Kazmerieweir MD
      Company or Employer: NVCC
      Title: President

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________

*****

3. Financial Interests

a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

✓ NO ____YES. If 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 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?

____NO ____YES. If YES, please provide details.

Don't Know – may through mutual funds

4. Beneficial and/or Employment Interests

a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

✓ NO ____YES. If YES, please provide details.

____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO ____ YES. If YES, please provide details.

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO ____ YES. If YES, please provide details.

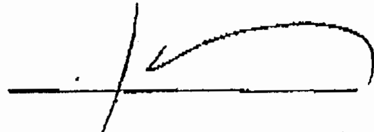
ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO ____ YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO ____ YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO ____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

8/21/14
Date

Please provide the following information:

Print Name: M.B. Kakmaciemi[illegible]

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

   Print Name: Clark Kearney
   Company or Employer: Saint Mary's Hospital
   Title: Vice President Human Resources

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Clark Kearney

*****

3. Financial Interests

a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

_X_ NO _____ YES. If 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 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?

_X_ NO _____ YES. If YES, please provide details.

____

4. Beneficial and/or Employment Interests

a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

_X_ NO _____ YES. If YES, please provide details.

____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

_X_NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
   _X_NO _____YES. If YES, please provide details.

   ____

   iii. Been indebted to or loaned money to a Tenet Entity.
   _X_NO _____YES. If YES, please provide details.

   ____

   iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

   _X_NO _____YES. If YES, please provide details.

   ____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Signature

8/18/14

Date

Please provide the following information:

Print Name: M. Clark Kearney

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

      Print Name: Sister Dolores Lahr, CSJ
      Company or Employer: Archdiocese of Hartford, CT
      Title: Victim Assistance Coordinator

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Sister Dolores Lahr, CSJ

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO ____ YES. If 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 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?

   ✓ NO ____ YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO ____ YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.

__✓__NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

Sister Dolores Lahr, CSJ   August 20, 2014

Signature   Date

Please provide the following information:

Print Name: Sister Dolores Lahr, CSJ

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

      Print Name: Angela Mattie
      Company or Employer: Quinnipiac University
      Title: Chair & Assoc Professor, Healthcare Management & Org Leadership

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Anderson Wa Hie

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO ____YES. If 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 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?

   ✓ NO ____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO ____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

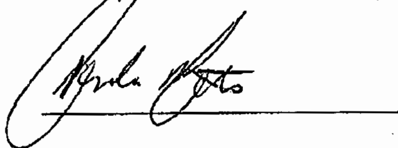
i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO _____YES. If YES, please provide details.

ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



8/21/14

Signature　　　　Date

Please provide the following information:

Print Name: Angela Martin

3

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

Print Name: Robert J. Mazaika
Company or Employer: ~~St~~ Retired
Title: Chairman of Board

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org by **Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ____________________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

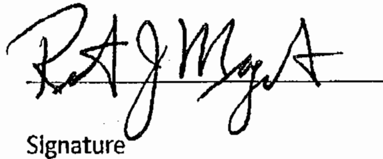
i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO _____YES. If YES, please provide details.

ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

8/18/14

Date

Please provide the following information:

Print Name: Robert J Mazaika

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

      Print Name: Joseph A Mengacci

      Company or Employer: Cassala Walsh + Wicklow, LLC

      Title: Attorney

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014**. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Joseph A. Mengacci

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      X NO _____YES. If 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 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?

      X NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      X NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

X NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
X NO _____YES. If YES, please provide details.

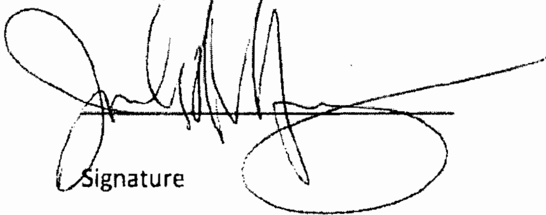
ii. Leased assets to or leased assets from a Tenet Entity.
X NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
X NO _____YES. If YES, please provide details.

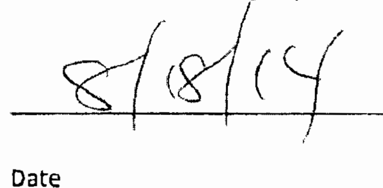
iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature



Date

Please provide the following information:

Print Name: Joseph B. Vellengacci

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: Michael Novak
      Company or Employer: Saint Mary's Hospital
      Title: VP of Operations, Ancillary Care and CIO

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Michael Novak

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      _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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      _X_ NO _____ YES. If 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 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?

      _X_ NO _____ YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      _X_ NO _____ YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

_X_NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
_X_NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
_X_NO _____YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

_X_NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

8/14/2014

Signature | Date

Please provide the following information:

Print Name: Michael Novak

Conflict of Interest/Financial Disclosure Form

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1. Instructions:
    a. Please provide the following information:

Print Name: Michael A. O'Brien
Company or Employer: Duncaster
Title: President and CEO

    b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

    c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Michael A. O'Brien

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      ✓ NO ______YES. If 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 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?

      ✓ NO ______YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      ✓ NO ______YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO ______YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
✓ NO ______YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO ______YES. If YES, please provide details.

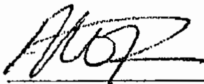
____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO ______YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.



8/21/14

Signature　　　　　　　　　　Date

Please provide the following information:

Print Name: Michael A. O'Brien

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

   Print Name: Richard E Pugh
   Company or Employer: ____________
   Title: Board member - St Mary's Hospital and Health Care System

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at **by Thursday, August 21, 2014. If you have any questions, please call Vicky at (203) 709-6471.**

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ______________________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      x NO ______YES. If 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 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?

      x NO ______YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      x NO ______YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

_x__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.

_x__NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.

_x__NO _____YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

_x__NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

August 21 2014

Signature Date

Please provide the following information:

Print Name: Richard E Pugh

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

   Print Name: Felix M. Rodriguez
   Company or Employer: State of CT - Judicial Branch
   Title: Compliance Specialist

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014**. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Felix M. Rodriguez

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   ✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   ✓ NO _____YES. If 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 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?

   ✓ NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   ✓ NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
__✓__NO _____YES. If YES, please provide details.

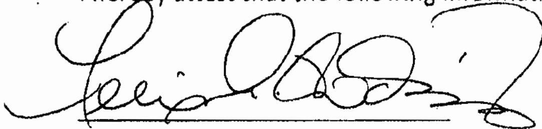
ii. Leased assets to or leased assets from a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



8/25/14

Signature Date

Please provide the following information:

Print Name: Felix M. Rodriguez

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:

   a. Please provide the following information:

Print Name: [illegible]
Company or Employer: [illegible]
Title: CEO

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Robert Rosso

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   X NO _____YES. If 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 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?

   X NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   X NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

X NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
X NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
X NO _____YES. If YES, please provide details.

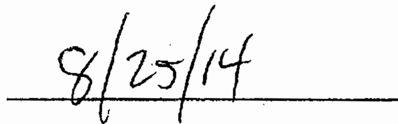
____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

Date

Please provide the following information:

Print Name: Robert R. Roscoe

000348

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

      Print Name: Steven Schneider
      Company or Employer: SAINT MARY'S HOSPITAL
      Title: CHIEF MEDICAL OFFICER

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Steven Schneider

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   X NO _____YES. If 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 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?

   X NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   X NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

X NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

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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.
X NO _____YES. If YES, please provide details.

____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.

8/14/14

Signature Date

Please provide the following information:

Print Name: Steven Schneider

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

      Print Name: PATRICK SIMERS
      Company or Employer: Principle Valuation
      Title: EXECUTIVE VICE PRESIDENT

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro of any such event or information as soon as possible.

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   b. Tenet Entity: Includes Tenet Healthcare Corporation, and its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: PATRick SIMERS

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   _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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   _X_NO _____YES. If 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 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?

   _X_NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   _X_NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

_X_ NO _____ YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
_X_ NO _____ YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
_X_ NO _____ YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

_X_ NO _____ YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 8/14/2014

Signature Date

Please provide the following information:

Print Name: Patrick J Simers

000354

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

Print Name: James C. Smith
Company or Employer: Webster Bank NA
Title: Chairman & CEO

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: James C. Smith

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   __✓__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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   __✓__NO _____YES. If 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 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?

   __✓__NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   __✓__NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

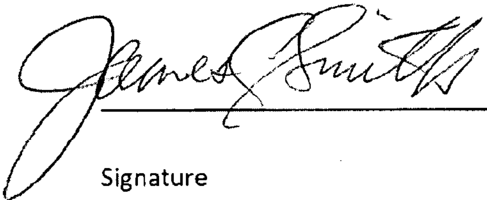
i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO _____YES. If YES, please provide details.

ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

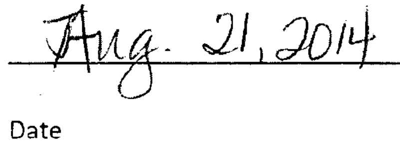
iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature



Date

Please provide the following information:

Print Name: James C. Smith

000357

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

      Print Name: Jerome Sugar[?]
      Company or Employer: NV ENT[?].
      Title: Surgeon

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org by Thursday, August 21, 2014. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Jerome Swan

*****

3. Financial Interests

a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

_✓_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

_✓_NO _____YES. If 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 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?

_✓_NO _____YES. If YES, please provide details.

____

4. Beneficial and/or Employment Interests

a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

_✓_NO _____YES. If YES, please provide details.

____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO _____YES. If YES, please provide details.

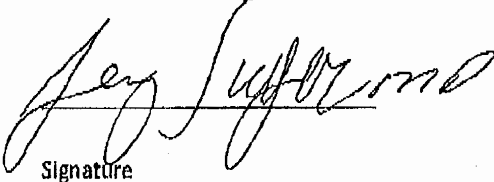
ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

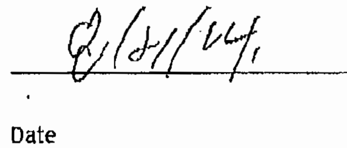
iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature



Date

Please provide the following information:

Print Name: Jerome Sucm

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

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1. Instructions:
   a. Please provide the following information:

      Print Name: Christine A. Sullivan
      Company or Employer: UConn Health Center / Duffy & Fasano
      Title: Atty / Researcher Asst.

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014.** If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: Christine A. Sullivan

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   _✓_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   _✓_NO _____YES. If 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 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?

   _✓_NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   _✓_NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

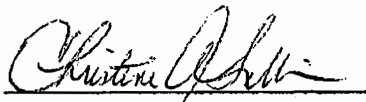
i. Sold or transferred assets to or purchased assets from or exchanged assets.
✓ NO _____YES. If YES, please provide details.

ii. Leased assets to or leased assets from a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

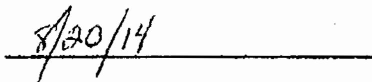
iii. Been indebted to or loaned money to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.
✓ NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature



Date

Please provide the following information:

Print Name: Christine A. Sullivan

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

   Print Name: JAMES TUCKER
   Company or Employer: SAINT MARY'S HOSPITAL
   Title: VP QUALITY, CNO

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: JAMES TUCKER

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

      _✓_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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

      _✓_NO _____YES. If 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 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?

      _✓_NO _____YES. If YES, please provide details.

      ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

      _✓_NO _____YES. If YES, please provide details.

      ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

__✓__NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet Entity?

i. Sold or transferred assets to or purchased assets from or exchanged assets.
__✓__NO _____YES. If YES, please provide details.

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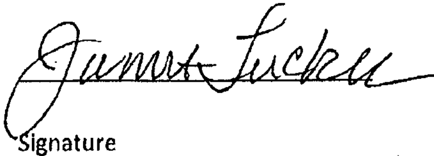
__✓__NO _____YES. If YES, please provide details.

iii. Been indebted to or loaned money to a Tenet Entity.
__✓__NO _____YES. If YES, please provide details.

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

__✓__NO _____YES. If YES, please provide details.

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

8/14/14

Date

Please provide the following information:

Print Name: JAMES TUCKER

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

      Print Name: James G. Uberti, MD
      Company or Employer: Franklin Medical Group / St. Mary's Health System
      Title: Physician (Internal Medicine / Primary Care)

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Vicky Cipriano at vcipriano@stmh.org **by Thursday, August 21, 2014**. If you have any questions, please call Vicky at (203) 709-6471.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Vicky 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: James G. Ubertini MD

*****

3. Financial Interests

a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

✓ 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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

✓ NO _____YES. If 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 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?

✓ NO _____YES. If YES, please provide details.

____

4. Beneficial and/or Employment Interests

a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

✓ NO _____YES. If YES, please provide details.

____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

_✓_NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
_✓_NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
_✓_NO _____YES. If YES, please provide details.

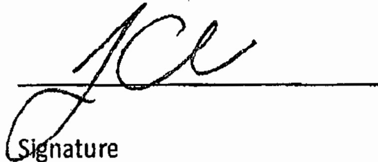
____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

_✓_NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.



Signature

8/21/14

Date

Please provide the following information:

Print Name: James A. Uberti, MD

000369

Conflict of Interest/Financial Disclosure Form

Saint Mary's Health System, Inc. and its affiliates ("Saint Mary's") proposes to sell substantially all of its assets to Tenet Healthcare Corporation ("Tenet") and to convert from not-for-profit to for-profit. The Certificate of Need application for this proposal requires the following individuals to complete this Conflict of Interest/Financial Disclosure form: (i) Saint Mary's Board members; (ii) subject matter experts involved in the transaction and (iii) senior executives with managerial responsibilities who have any direct involvement in the transaction

---

1. Instructions:
   a. Please provide the following information:

   Print Name: Chad W. Wable
   Company or Employer: Saint Mary's Hospital
   Title: President + CEO

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org by **Tuesday, August 19, 2014.** If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: [signature]

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   X NO _____YES. If 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 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?

   X NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   X NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

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.
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____

ii. Leased assets to or leased assets from a Tenet Entity.
X NO _____YES. If YES, please provide details.

____

iii. Been indebted to or loaned money to a Tenet Entity.
X NO _____YES. If YES, please provide details.

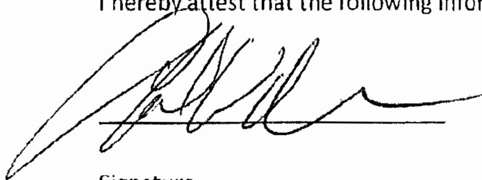
____

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO _____YES. If YES, please provide details.

____

I hereby attest that the following information is true and accurate to the best of my knowledge.



8/18/14

Signature | Date

Please provide the following information:

Print Name: Chad W. Wable, FACHE

Conflict of Interest/Financial Disclosure Form

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---

1. Instructions:
   a. Please provide the following information:

   Print Name: Elaine Yao
   Company or Employer: Hammond Hanlon Camp LLC
   Title: Managing Director

   b. Please mark the appropriate box in each question. Please include activities occurring currently or during the past year. Please return the completed questionnaire to Ann Ferraro at aferraro@stmh.org **by Tuesday, August 19, 2014**. If you have any questions, please call her at (203) 709-6093.

   c. Retain a completed copy of this questionnaire for your files. If, following your return of the questionnaire, any events occur or information comes to your attention that would affect the accuracy of any of your questions in this questionnaire, please notify Ann Ferraro 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 partners (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 an 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 its subsidiaries and affiliates including those listed on Exhibit A attached to this form.

Print Name: ____________________

*****

3. Financial Interests

   a. Do you or any Related Person have a direct or indirect ownership interest in any Tenet Entity (see definitions on first page)?

   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 January 1, 2013, did you or any Related Person have a compensation arrangement, including without limitation, as an employee or consultant, with any Tenet Entity?

   X NO _____YES. If 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 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?

   X NO _____YES. If YES, please provide details.

   ____

4. Beneficial and/or Employment Interests

   a. Since January 1, 2013, were you or any Related Person offered a position as a director or trustee of a Tenet Entity?

   X NO _____YES. If YES, please provide details.

   ____

b. Since January 1, 2013, were you or any Related Person offered a consulting position or employment with a Tenet Entity?

X NO _____YES. If YES, please provide details.

---

c. Since January 1, 2013, have you or any Related Person engaged in any of the following transactions with a Tenet 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.
X NO _____YES. If YES, please provide details.

___

iii. Been indebted to or loaned money to a Tenet Entity.
X NO _____YES. If YES, please provide details.

___

iv. Furnished or acquired goods, services or facilities to a Tenet Entity.

X NO _____YES. If YES, please provide details.

___

I hereby attest that the following information is true and accurate to the best of my knowledge.

[signature] 8-26-2014

Signature Date

Please provide the following information:

Print Name: Elaine Yao

J

Conflict of Interest/Financial Disclosure Form

This Conflict of Interest/Financial Disclosure Form is being completed as part of the Saint Mary's Health System, Inc.'s ("Saint Mary's") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of Saint Mary's to VHS Saint Mary's Health System, LLC, a to-be-formed, for profit entity owned by Tenet Healthcare Corporation ("Tenet") (the "Transaction").

Certain senior executives of Tenet 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 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 this Disclosure Form no later than September 10, 2014, to Collin Baron, 850 Main Street, Bridgeport, CT 06601 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 Collin Baron 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) **Saint Mary's Entity:** includes Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc.; Saint Mary's Hospital Foundation, Inc.; The Harold Leever Regional

Cancer Center, Inc.; Heart Center of Greater Waterbury, Inc.; Saint Mary's Indemnity Company, LLC; Franklin Medical Group, P.C.; Diagnostic Imaging Center of Southbury, LLC; Naugatuck Valley MRI; and Saint Mary's Physician Partners, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Saint Mary's 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 January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Saint Mary's 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 Saint Mary's Entity?

__X__ NO ______YES. If YES, please provide details. ______________

____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Saint Mary's Entity, VHS Saint Mary's Health System, LLC, or the Local Advisory Board to be formed as part of the Transaction?

______ NO __X__ YES. If YES, please provide details. At the closing, I would be on the board of directors of the Trust subsidiary that owns the hospital.

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Saint Mary's Entity, VHS Saint Mary's Health

System, LLC, or the Local Advisory Board to be formed as a part of the Transaction?

X NO ______YES. If YES, please provide details. ____________________

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Saint Mary's Entity?

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(ii) Leased assets to or leased assets from a Saint Mary's Entity?

X NO ______YES. If YES, please provide details. ____________________

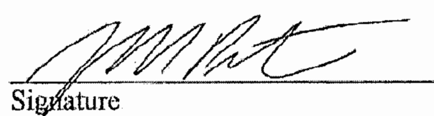
(iii) Been indebted to or loaned money to a Saint Mary's Entity?

X NO ______YES. If YES, please provide details. ____________________

(iv) Furnished or acquired goods, services or facilities to a Saint Mary's Facility?

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

9/5/14

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 this Disclosure Form no later than September 10, 2014, to Collin Baron, 850 Main Street, Bridgeport, CT 06601 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 Collin Baron of any such event or information as soon as possible.

2. **Definitions:**

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Cancer Center, Inc.; Heart Center of Greater Waterbury, Inc.; Saint Mary's Indemnity Company, LLC; Franklin Medical Group, P.C.; Diagnostic Imaging Center of Southbury, LLC; Naugatuck Valley MRI; and Saint Mary's Physician Partners, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Saint Mary's 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 January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Saint Mary's 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 Saint Mary's Entity?

✓ NO ______YES. If YES, please provide details. ____________________

____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Saint Mary's Entity, VHS Saint Mary's Health System, LLC, or the Local Advisory Board to be formed as part of the Transaction?

✓ NO ______YES. If YES, please provide details. ____________________

____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Saint Mary's Entity, VHS Saint Mary's Health

System, LLC, or the Local Advisory Board to be formed as a part of the Transaction?

__✓__ NO ______YES. If YES, please provide details. ____________________

____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Saint Mary's Entity?

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__✓__ NO ______YES. If YES, please provide details. ____________________

____

(ii) Leased assets to or leased assets from a Saint Mary's Entity?

__✓__ NO ______YES. If YES, please provide details. ____________________

____

(iii) Been indebted to or loaned money to a Saint Mary's Entity?

__✓__ NO ______YES. If YES, please provide details. ____________________

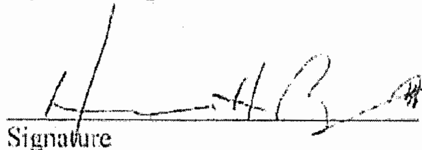
____

(iv) Furnished or acquired goods, services or facilities to a Saint Mary's Facility?

__✓__ 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

9-8-14

Date

Harold W. Pilgrim, III

Printed Name

Conflict of Interest/Financial Disclosure Form

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Certain senior executives of Tenet 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 certain senior executives of Tenet who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Keith Pitts

(b) Please complete and return this Disclosure Form no later than September 10, 2014, to Collin Baron, 850 Main Street, Bridgeport, CT 06601 or cbaron@pullcom.com. If you have any questions regarding the Disclosure Form, please contact Collin Baron at 203-330-2219.

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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 Saint Mary's 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 January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Saint Mary's 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 Saint Mary's Entity?

__✓__ NO ______ YES. If YES, please provide details. ____________________

____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Saint Mary's Entity, VHS Saint Mary's Health System, LLC, or the Local Advisory Board to be formed as part of the Transaction?

__✓__ NO ______ YES. If YES, please provide details. ____________________

____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Saint Mary's Entity, VHS Saint Mary's Health

System, LLC, or the Local Advisory Board to be formed as a part of the Transaction?

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____

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____

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____

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____

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✓ NO ______YES. If YES, please provide details. ____________________

____

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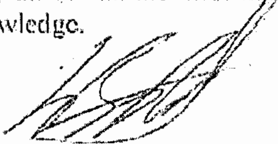

______________________________ 9/5/14
Signature Date

Keith Potts
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 this Disclosure Form no later than September 10, 2014, to Collin Baron, 850 Main Street, Bridgeport, CT 06601 or cbaron@pullcom.com. If you have any questions regarding the Disclosure Form, please contact Collin Baron at 203-330-2219.

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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?

__✓__ NO ______YES. If YES, please provide details. ______________

____

(d) Do you or any Related Person own stock or options to purchase stock in any Saint Mary's Entity?

__✓__ NO ______YES. If YES, please provide details. ______________

____

4. **Beneficial and/or Employment Interests**

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__✓__ NO ______YES. If YES, please provide details. ______________

____

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____

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____

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__✓__ NO ______YES. If YES, please provide details. ____________________

____

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____

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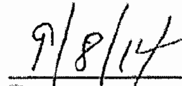
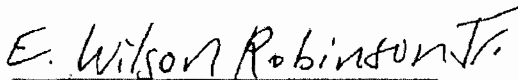
Signature



Date



Printed Name

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Please provide the following information:

Print Name: ERIK WEXLER

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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. ____________________

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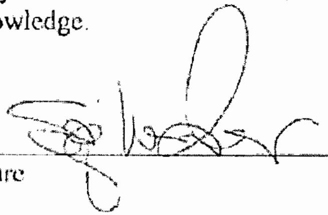

Signature

9/8/14

Date

Gisle Wexler

Printed Name

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.

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Principle Valuation, LLC

PEOPLE AND VALUES YOU CAN TRUST

June 16, 2014

Saint Mary's Health System, Inc.
56 Franklin Street
Waterbury, Connecticut 06706

Attention: Mr. Chad Wable
CEO

Re: Fairness Opinion for the purchase of Saint Mary's Health System by Tenet Healthcare

Gentlemen:

This letter serves as our proposal to provide financial analysis and services requested by your attorney Robert J. Anthony for Saint Mary's Health System, Inc. ("Saint Mary's") in connection with the purchase ("Transaction") of Saint Mary's by Tenet Healthcare ("Tenet").

PURPOSE

In connection with this Transaction we understand that you will need prepared a fairness evaluation as to whether, in our opinion, the consideration set for in the Transaction is fair from a financial point of view in order to assist the Board in meeting its fiduciary duties and obligations under the State of Connecticut's General Statute t19a-486 et seq. ("Conversion Statute"). The date of our analysis will be June 1, 2014.

SCOPE

In determining whether the consideration is fair from a financial point of view under the Connecticut Statute we will address the following valuation issues and considerations:

- Assess the "Fair Market Value" of the Assets to be transferred to Tenet by St. Mary's
- Assess the value of the financial benefits received by St. Mary's by entering into the transaction

In conducting these assessments the following considerations will be made:

- Review the terms associated with the Transaction

- Conduct a site visit to the Hospital to accurately describe and assess the condition of the assets to be transferred. This visit should be brief and serve to verify information originally obtained about the site during our prior analysis.
- Review the historical and earning potential of the operating assets that St. Mary's intends to transfer
- Review the plans, budgets, and financial projections associated with the subject in the absence of a Transaction
- Consider the overall market potential of the St. Mary's
- Review and extrapolate from transactions that involved for-profit versus not-for-profit organizations and academic hospital systems versus community hospital systems
- Review and analyze other pertinent and necessary information necessary to arrive at our final opinions
- Working Capital Assets; Foundation Restricted Assets; and Assets Held as Marketable Securities will be valued based upon the balances stated on the Balance Sheets provided.
- Liabilities Assumed by the Purchaser including Pension Fund Liabilities will be valued based upon their current Balances as Stated on the Balance Sheets provided.

USE

These valuation-consulting services are intended to assist your client in their assessment of the overall contemplated Transaction. Our work is not intended to establish specific pricing recommendations; rather, it is designed to provide you with relevant data that will allow it to make an informed decision. We understand that report may be requested by Connecticut's Attorney General in his overall assessment of the transaction and that we may be required to respond to some of his enquiries about our overall analysis.

REPORTING COMMITMENTS

Our report will be a brief opinion letter and will only validate (or not) the overall fairness of the transaction from a financial point of view. We will also prepare a back-up document that will support our overall conclusions in a summary fashion to present to the Board and or the Attorney General's office. We anticipate being able to prepare our report and deliver a draft analysis within Four weeks of receipt of the necessary information. Should your timing be more critical we would work with you to meet these deadlines.

PROCESS TIMELINE, LOGISTICS, AND COORDINATION

We would anticipate the following general time line which would lead to an overall engagement completion.

- First Week — Receipt of data; arrange visit
- Second Week — Review of data received; prepare financial models
- Third Week — Prepare Draft Documents and forward
- Fourth Week — Discuss findings and Prepare final documents

We believe that this time line is reasonable based upon the overall effort and personnel that would be involved in this analysis. Should a tighter time frame be needed, we may be able to accommodate. All time estimates assume that all data requests are promptly received on an ongoing basis throughout the engagement process. We would immediately notify you should any delays in the receipt of information or other items beyond our control would push back these delivery timelines.

DUE DILIGENCE DATA REQUIREMENTS

The following information will be initially and primarily required in order to complete the assignment:

- A Central Contact that is familiar with the overall operations and contemplated transaction. This person will serve as our primary contact and should be able to discuss the financial, and market environment for the assets under consideration. Further this person should have the ability to coordinate site visits with our staff with the Hospital
- Audited Financial Statements of St. Mary's and its primary operating units for the past three years along with the current year-to-date operations and budgets.
- Forecasted operations for the next three-five year period for St. Mary's in the absence of the Transaction
- A copy of the most recent Contribution/Purchase Agreement between St. Mary's and Vanguard
- A current Balance Sheet of the Organization and an explanation of which assets are anticipated to transfer
- An estimate of the Net Proceeds of the Transaction as of March 31, 2014 Balance Sheet
- A copy of the current fixed asset ledger of the Hospital in an excel format
- A listing of all real estate property anticipated to transfer with the transaction; including the address of the property, a brief description of the improvements including its size and use, its associated tax parcel number, and the size of the underlying land parcel
- A copy of any Board Minutes that discussed the contemplated Transaction
- A copy of any reports or presentations that your financial advisors prepared in making its overall recommendations to the Board

- The Management and Organizational Structure associated with the Joint Venture
- Any Demographic, Market Research, or Competitive Surveys that were conducted to support the overall merger
- Any other data that you feel is necessary that enhances our understanding of the Transaction

FEE

Our fee for this engagement will be $ plus out-of-pocket travel expenses. We will bill an initial retainer in the amount of $ that we anticipate will be paid upon acceptance of the assignment. The total fee is based on our estimate of professional services to be furnished, according to our understanding of your requirements; should the scope of these requirements change, Principle Valuation and St. Mary's will mutually revise the fee to reflect those changes in services. Our fee is in no way contingent upon the outcome of our conclusions.

Fees include professional time for planning and executing the work through, and including, our final report. Should you require additional consultation based on your reviews of our work or those of your external auditors or your tax or other advisors, or any public presentation be required we will bill for those services at our prevailing hourly rate for the personnel involved.

We reserve the right to withhold delivery of our preliminary conclusions or final report(s) if, when either of these is ready for delivery, any previously issued invoice remains unpaid. We reserve the right to issue interim or final invoices, as appropriate, should you delay the project and/or in the event that our preliminary or draft report has been in your possession for more than 30 days.

You have the right to terminate this assignment at any time, in which case there will be no further obligation on the part of either party to continue. In such event, you will be obligated to pay only for the actual time and charges accumulated through the date of cessation.

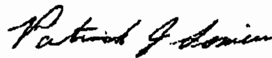
St. Mary's agrees to indemnify and hold harmless Principle Valuation, its employees, and representatives, collectively ("Principle") from and against any and all losses, claims, damages, or liabilities, joint or several, including all reasonable out-of-pocket expenses, fees, and disbursements of counsel incurred by Principle in defending any claim, action, or proceeding whether or not resulting in a liability to Principle to which they may become subject, caused by, arising out of or in connection with this engagement, including but not limited to, losses, claims, damages or liabilities caused by or arising out of any untrue statements of material fact contained in the information provided to Principle by St. Mary's or its advisors in connection with our engagement, or any omission to state any therein any material fact required or necessary to make the information not misleading in light of circumstances under which given, or any violation of the federal securities laws or the securities laws of any state, or otherwise arising out of our engagement hereunder except in respect to any matter as to which Principle shall have been adjudicated to have acted with gross negligence or willful malfeasance.

ACKNOWLEDGEMENT

We appreciate this opportunity to provide our recommendations for valuation-consulting services and look forward to working with you on this important engagement. We are uniquely qualified to perform this assignment, by virtue of our independence, experience, reputation, and expertise. We are committed to completing the work in an efficient and timely manner.

If the content of this document correctly reflects your understanding of our agreement, please sign below and return the executed document and return the enclosed copy. This agreement shall remain open and valid for signature for 90 days from the issue date; however, any significant delay in executing this agreement could adversely impact our ability to meet the delivery commitments described herein. Please note we will be unable to start this engagement until we are in receipt of this signed acknowledgment. To avoid any delays in delivery, please fax the signed acknowledgment to 312 422-1515. Thereafter, please forward the original to us.
If you have any questions or comments, please call me at 770 924-8811.
Respectfully submitted,

PRINCIPLE VALUATION, LLC



Patrick J. Simers
PJS/pjs

CLIENT: ______________________

SIGNATURE(S): ______________________

NAME (PRINT OR TYPE): ______________________

TITLE: ______________________

DATE: ______________________

PHONE: ______________________

ADDENDA

TIMOTHY H. BAKER
PRESIDENT

EXPERIENCE

Mr. Baker has been in the appraisal industry since 1981 with a concentration on healthcare and senior living properties. His valuation experience includes valuing the business enterprise, real estate, and personal property. Valuations have been performed on a national and international basis. Consulting engagements include market and financial feasibility studies.

Mr. Baker has experience in the valuation of numerous healthcare facilities including acute care, behavioral health, and rehabilitation hospitals. Senior living properties include nursing homes, assisted living facilities, and retirement centers. Other related operations include research facilities, healthcare leasing companies, physician practices, and medical office buildings. Mr. Baker has also provided consultations on market assessment, demand analysis, reimbursement issues, development of fixed asset records, and provided analysis of strategic opportunities. Valuation reports prepared by Mr. Baker have been used for several purposes including public offerings, litigation support, HUD 232 and 242 mortgage insurance programs, acquisition/divestitures, property tax purposes, state reimbursement, estate planning, and for internal management decision making.

PROFESSIONAL HISTORY

- 2007 to present – President, Principle Valuation, LLC.
- 2001 to 2007 - Senior Vice President, Wellspring Valuation, Ltd.
- 1997 to 2001 - Vice President, Marshall & Stevens National Healthcare Practice.
- 1992 to 1997 - Senior Manager, Capital Valuation Group, specializing in the valuation of the business and real estate of senior living and healthcare related facilities.
- 1981 to 1992 – Manager, Valuation Counselors where he was responsible for performing a multitude of appraisal and consulting services for clients specializing in business enterprise, real estate, and machinery and equipment.

PROFESSIONAL AFFILIATIONS

- Advisory Committee Member American Senior Housing Association
- Healthcare Financial Management Association
- American Health Lawyers Association
- Associate Member Appraisal Institute

EDUCATION LICENSES, AND DESIGNATIONS

- 1980 graduate of Bucknell University with a Bachelor of Science in Business Administration
- Certified General Real Estate Appraiser Maryland and New Jersey

TESTIMONY

- Testified as expert witness in California, Colorado, Connecticut, New Hampshire, New Jersey and Pennsylvania

PATRICK J. SIMERS
EXECUTIVE VICE PRESIDENT

EXPERIENCE

Mr. Simers has extensive experience in serving the valuation needs of the health-care industry. He has valued all tangible and intangible assets associated with health-care enterprises, including the capital stock of majority and minority share holdings; medical specialty and physician joint ventures; fee simple, leased fee, and leasehold interests in real estate for hospital systems, stand-alone hospital campuses, and medical office buildings; major and minor movable equipment; certificates of need; contractual agreements; and preferred provider arrangements.

Specific healthcare enterprises appraised include acute care hospital facilities, LTACH hospitals, psychiatric hospitals, rehab hospital facilities, single physician practices, multi-specialty practices, cath labs, diagnostic centers, cardiac care practices, home health agencies, nursing homes, assisted living facilities, and medical office buildings.

Mr. Simers has performed fair market value studies for purchase, sale, or financing; merger and acquisition consulting; negotiation of purchase price; fairness opinions; purchase price allocations; financial reporting; SEC reporting; Medicare regulatory requirements; Safe Harbor requirements; and 501(c)(3) private placement offerings.

PROFESSIONAL HISTORY

Mr. Simers began his appraisal career with Valuation Counselors in 1982 and held various consulting, business development, and management roles, including four years as president of Valuation Counselors, leading up to its merger with CBIZ Inc. Most recently, Mr. Simers has served as the National Director for Healthcare services for American Appraisal Associates where he spear-headed the development of healthcare services for this international appraisal firm.

Patrick J. Simers is Executive Vice President for Principle Valuation. He is responsible for the development and overall business plan for Principle's consulting and appraisal services to for-profit, nonprofit, and public health-care providers. Mr. Simers is located in Principle Valuation's Atlanta office.

PROFESSIONAL AFFILIATIONS

- American Health Lawyers Association
- Healthcare Financial Management Association

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Northern Illinois University with a Bachelor of Science in Finance and Economics
- Graduate of Moraine Valley College with a Associate in Arts in Business Administration
- Certified General Real Estate Appraiser in Georgia

MARY JO DUFFY

EXPERIENCE

Ms. Duffy brings 25 years of accounting, auditing, business valuation, business consulting and financial management to her clients. She has testified as an expert witness in deposition and trial, and advised clients on strategy, transactions and general business issues in addition to valuation issues

Ms. Duffy began her career with KPMG as an accountant and auditor. As CEO of Valuation Counselors, a national valuation firm, she provided valuation services to entities as diverse as boat manufacturers, grocery chains, technology ventures and healthcare providers. She served as a partner in a national CPA firm, responsible for appraisal and valuation services nationwide and was a member of the firm's Management Council.

As National Director of Financial Services to the healthcare industry for Coopers & Lybrand L.L.P., a predecessor firm of PricewaterhouseCoopers, Ms. Duffy was responsible for litigation, valuation, merger & acquisition, reorganization and other services to healthcare entities and assisted healthcare clients with matters involving providers, payers and related organizations. She later joined Ernst & Young's Healthcare Consulting practice specializing in physician networks, operations improvement, M&A strategy and post-merger integration. Her expertise in the healthcare arena includes advising providers on strategic options, negotiating transactions and assisting a Debtor in Possession in disposing of the assets, preparing a physician organization for doubling in size and an IPO, and developing integrated networks in academic medical centers and community delivery systems. She has also been the CFO of multi-specialty, multi-site healthcare provider.

PROFESSIONAL HISTORY

- Director, Acuitas, Inc.
- Senior Manager/Director, Ernst & Young Healthcare Consulting, LLC
- National Director of Financial Services, Coopers & Lybrand, LLC
- CEO, Valuation Counselors Group
- Certified Public Accountant and Auditor, KPMG

PROFESSIONAL AFFILIATIONS

- Leadership Team Member Healthcare Task Force of Georgia Society of CPAs
- Member, Illinois CPA Society
- Serves as Board Member for: Turning Point Women's Healthcare, The Childhood Autism Foundation and Emory Austin Resource Center
- Georgia Association of Healthcare Executives

EDUCATION LICENSES, AND DESIGNATIONS

- Graduate of Georgetown University School of Business
- Certified Public Accountant

HONORABLE DESIGNATIONS

- Honored by Atlanta Magazine as one of Atlanta's outstanding business women.

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FAIRNESS OPINION

SAINT MARY'S HEALTH SYSTEM
56 FRANKLIN STREET
WATERBURY, CONNECTICUT 06708

SUBMITTED TO:
SAINT MARY'S HEALTH SYSTEM
ATTENTION: MR. CHAD WABLE
CHIEF EXECUTIVE OFFICER
56 FRANKLIN STREET
WATERBURY, CONNECTICUT 06708

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

August 27, 2014

Saint Mary's Health System
56 Franklin Street
Waterbury, Connecticut 06706

Attention: Mr. Chad Wable
Chief Executive Officer

Re: Fairness Opinion for Potential Sale of Saint Mary's Health System, Inc. to Vanguard Health Systems, Inc.

Ladies and Gentlemen:

Pursuant to the Asset Purchase Agreement, (draft dated May 30, 2014), Saint Mary's Health System, Inc. and its subsidiaries ("Saint Mary's") will be sold to VHS Saint Mary's Health System, LLC ("VHS") (the "Transaction"). VHS Saint Mary's Health System is owned by VHS Connecticut, LLC with Tenet Healthcare Corporation ("Tenet Healthcare") as an indirect owner. Pursuant to the proposed Transaction the Board of Saint Mary's has asked Principle Valuation to provide the Board a fairness evaluation of the Transaction to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 19a-486 et seq. ("Conversion Statute"). The date of our analysis is June 1, 2014 giving consideration to historical data available as of May 31, 2014 and subsequent financial data provided to us by Saint Mary's and their financial consultants.

KEY ELEMENTS OF THE TRANSACTION

We have included the draft of the Asset Purchase Agreement provided to us in the Addenda of this report. Key elements of the transaction include the following:

- VHS will purchase Saint Mary's Assets (inclusive of $6,300,000 of net working capital) for $150,000,000;
- VHS will assume pension plan liabilities of Saint Mary's, the retiree medical plan, and the value of capital leases. The value of the pension liability as of May 31, 2014 was $52,518,000. We have not independently verified the value of these liabilities and assume the value stated on the balance sheet and/or final closing statements provided to us reflects fair market value;
- VHS will make a commitment to expend $85,000,000 in capital projects, including routine and non-routine capital expenditures over a seven year time frame.

The Asset Purchase Agreement include additional understandings and terms not directly related to the financial aspects of the transaction. Although we recognize that these terms may have a bearing on the overall acceptance of the transaction by either party; we have not independently analyzed all of these non-financial items.

SCOPE

In determining whether the consideration is fair from a financial point of view, we have compared the financial rights and responsibilities that currently are held by Saint Mary's with the proposed sales terms. In arriving at the opinion set forth below, we have among other things:

- Visited the Saint Mary's Hospital site to describe and assess the overall condition of the physical assets and improvements A complete site inspection was conducted in February 2012 a brief inspection was performed in August 2014;
- Been provided and reviewed certain available business and financial information relating to Saint Mary's that was provided by Saint Mary's management team, including audited financial statements for the fiscal years ended September 30, 2011, 2012, and 2013 and internally prepared financial statements for the period ended May 31, 2014;
- Been provided with and relied upon the forecast of operations for fiscal 2014 through fiscal 2017 prepared by Saint Mary's management as a Stand-Alone organization if the transaction does not occur;
- Reviewed the Draft Asset Purchase Agreement by and among Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., VHS of Connecticut, LLC, VHS Saint Mary's Health System, LLC, and Tenet Healthcare Corporation dated May 30, 2014;
- Reviewed minutes of the Board of Directors of Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. for the period September 13, 2012 through May 22, 2014; reviewed Transaction Team minutes for the period June 3, 2011 through May 19, 2014;
- Reviewed the reports prepared by H2C, including the Board Discussion report dated as of June 19, 2014 and the Taskforce issues List and Transaction Risks report;
- Considered the criteria set forth in Conversion Statute;
- Interviewed members of Saint Mary's management;
- Reviewed such other financial studies and analysis and took into account such other matters as we deemed necessary, including our assessment of general economic market and monetary conditions;
- Reviewed the historical market prices, trading activity and valuation multiples of certain publicly traded companies that we deemed to be relevant and used them as benchmarks to estimate relative criteria in our analysis; and

- Compared the proposed financial terms of the proposed purchase with certain other transactions that we deemed relevant.

In preparing our opinion, we have assumed and relied on the accuracy and completeness of all information supplied or otherwise made available to us, discussed with or reviewed by or for us, or publically available, and we have not assumed any responsibility for independently verifying such information. Nor have we evaluated the solvency or fair value of Saint Mary's under any state or federal laws relating to bankruptcy, insolvency, or similar matters.

We have made a physical visit to the Saint Mary's Hospital and have assessed the value of the depreciated replacement cost of the fixed assets currently present at the site. The inspection was conducted in February 2012, with a brief visit in August 2014, and upon representations of management and our inspection we believe that the overall condition of the assets are in fair condition for their age. With respect to the financial forecast provided to or discussed with us by representatives of Saint Mary's, we have assumed that they have been reasonably prepared and reflect the best currently available estimates and judgment of Saint Mary's as to the expected future financial performance of Saint Mary's. We have also assumed that the final form of the Asset Purchase Agreement will be substantially similar to the draft reviewed by us dated May 30, 2014.

Our opinion is based upon market, economic and other conditions as they exist and can be evaluated, and on the information made available to us as of the date hereof. We have assumed that there are no undisclosed or unexpected conditions that would affect the value of Saint Mary's assets or the financial condition or operations of Saint Mary's or the expected future financial performance of Saint Mary's. We have assumed that in the course of obtaining the necessary regulatory or other consents or approvals (contractual or otherwise) for the Transaction, no restrictions, including any amendment or modifications, will be imposed that will have a material adverse effect on the transaction.

In connection with the preparation of this opinion, we have not been authorized by Saint Mary's to solicit, nor have we solicited, third-party indications of interest for the acquisition of Saint Mary's interest.

We are not acting as a financial advisor to any party in this arrangement. Our fees for this engagement are not dependent upon the opinion rendered. Several years ago we performed work for Vanguard Health Systems. Saint Mary's has agreed to indemnify us for certain liabilities arising out of our engagement.

USE

These valuation-consulting services are intended to assist the Board in meeting its fiduciary duties and obligations under the Conversion Statute. Our work is not intended to establish specific pricing recommendations; rather, it is designed to provide the Board with relevant data that will allow it to make an informed decision. Our opinion does not constitute a recommendation regarding the proposed transaction, or any matter related thereto.

We understand that the report may be requested by Connecticut's Attorney General in his overall assessment of the transaction and that we may be required to respond to some of his inquiries about our overall analysis.

CONCLUSIONS

We understand that under the Conversion Statute, the Attorney General shall deny an application as not in the public interest if the Attorney General determines that one or more of the following conditions exist and, as requested by Saint Mary's, we respond to these criteria below to the best of our knowledge and expertise:

(1) The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities;

Please note that we are not admitted to practice law in Connecticut and are not qualified to make this opinion. Saint Mary's has indicated to us that there is no absolute prohibition of the Transaction by Connecticut statutory or common law governing nonprofit entities, trusts or charities, other than the requirements of the Conversion Statute must be satisfied.

(2) The nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer;

Having reviewed the minutes of the Board and the Transaction Team, and speaking with Saint Mary's management, counsel and financial advisors, we find that the Board has exercised due diligence in deciding to transfer, selecting Vanguard as the purchaser, and negotiating the terms and conditions of the transfer.

Principle Valuation, Inc. ("Principle") responded to an RFP issued by Saint Mary's, provided its qualifications and was chosen after a review of those qualifications and an interview. Principle is independent; it is being paid a flat non-contingent fee for its work on the Transaction. Its expertise in such transactions is enumerated in the Addendum.

(3) The nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the hospital, the purchaser or any other party to the transaction;

We have not conducted any review in this regard.

(4) The nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market;

On the basis of and subject to the foregoing, we are of the opinion that, as of June 1, 2014, the Consideration set forth in the Transaction is fair from a financial point of view to Saint Mary's and that Saint Mary's is receiving fair market value for its assets.

(5) The fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease;

As noted previously, we have performed reviews of Saint Mary's financial condition and assets and find no indication that the fair market value of its assets have been manipulated by any person in a manner that causes the value of the assets to decrease.

(6) The financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk;

The Transaction does not encumber Saint Mary's with any financing for the completion of this transaction; consequently, there is no financing of the proposed transaction that would place the nonprofit hospital's assets at an unreasonable risk upon commencement of the Transaction.

(7) Any management contract contemplated under the transaction is not for reasonable fair value;

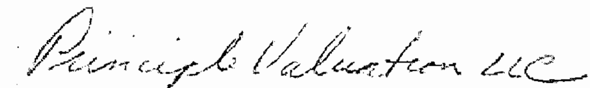
We have not been made aware of any management contracts contemplated under the transaction.

(8) The nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately.

Principle Valuation is not acting, in any fashion, as an agent of the Transaction; and therefore has no opinion as to whether or not all data and information sufficient to evaluate the proposed transaction has been provided to the Attorney General. Saint Mary's advises us that the Attorney General has not concluded its request for information with respect to the Transaction nor has, as of the date, hereof, Saint Mary's submitted its application.

Respectfully submitted,

PRINCIPLE VALUATION, LLC



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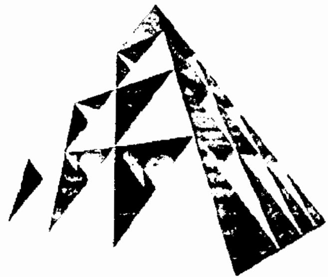

Principle Valuation, LLC

PEOPLE AND VALUES YOU CAN TRUST

Saint Mary's Health System, Inc.
Fairness Opinion - Qualitative & Quantitative Considerations
August 27, 2014

Introduction and Background

Pursuant to the Asset Purchase Agreement, (draft dated May 30, 2014), Saint Mary's Health System, Inc. and its subsidiaries ("Saint Mary's" or "St. Mary's") will be sold to VHS Saint Mary's Health System, LLC ("VHS") (the "Transaction"). VHS Saint Mary's Health System is owned by VHS Connecticut, LLC with Tenet Healthcare Corporation ("Tenet Healthcare") as an indirect owner. Pursuant to the proposed Transaction the Board of Saint Mary's has asked Principle Valuation to provide the Board a fairness evaluation of the Transaction to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute 19a-486 et seq. ("Conversion Statute").

The Fairness Opinion will be provided in a separate letter. This document is presented to the Board and Financial Advisors of Saint Mary's as a supplemental document to highlight the overall process and primary assumptions utilized in arriving at our final conclusion. This document is not being specifically prepared to present to the Attorney General ("AG"); it is a high level document that should be reviewed by the Board and its Financial Advisors for accuracy with respect to the historical information contained herein and general agreement as to underlying operating assumptions utilized. Similar schedules or explanations may be required by the AG upon his review of the final Fairness Opinion and the Transaction in general.

Outline of Proposed Transaction

In the proposed transaction, Saint Mary's Health System, Inc. and its subsidiaries ("Saint Mary's" or "St. Mary's") will be sold to VHS Saint Mary's Health System, LLC ("VHS"). VHS Saint Mary's Health System is owned by VHS of Connecticut, LLC with Tenet Healthcare Corporation as an indirect owner.

Key elements of the transaction are as follows:

- VHS will purchase Saint Mary's Assets (inclusive of $6,300,000 of net working capital) for $150,000,000;
- VHS will assume pension plan liabilities of Saint Mary's, the retiree medical plan, and the value of capital leases. The value of the pension liability as of May 31, 2014 was $52,518,000. We have not independently verified the value of these liabilities and assume the value stated on the balance sheet and/or final closing statements provided to us reflects fair market value;
- VHS will make a commitment to expend $85,000,000 in capital projects, including routine and non-routine capital expenditures over a seven year time frame.

Assets Anticipated to Transfer

Saint Mary's will sell substantially all of its operating assets, including Saint Mary's Hospital, Inc (the "Hospital"), and joint venture interests. This would include all the tangible and intangible assets currently utilized in the Hospital's operations. Tangible assets would include a net working capital balance of $6,300,000, inventories and supplies, insurance, the real estate and equipment. Intangible assets would include the operating licenses, contracts, tradenames, trademark, web sites, etc. All assets will be transferred essentially free and clear of any encumbrances.

Excluded from the transaction:

- Saint Mary's Indemnity Company, LLC
- Saint Mary's Hospital Foundation, Inc.
- Harold Leever Regional Cancer Center, Inc.
- Heart Center of Greater Waterbury, Inc

There will be a net working capital adjustment at closing. Based on the May 31, 2014 balance sheet, the expected adjustment is $4,622,000.

The allocation of the balance sheet as of May 31, 2014 between assets and liabilities acquired by VHS and those retained by the Foundation along with the Net Proceeds Calculation prepared by Management is presented on the following schedules.

Net Proceeds Calculation Prepared By Management

Saint Mary's Health System ($ in thousands)	May 2014 Pre Close	Tenet Purchase	Fund Pension	Eliminate Debt	Saint Mary's Consolidated Post Close
Cash	$ 26,495	$ 135,000	$ (52,518)	$ (17,321)	$ 91,656
Restricted Cash		15,000			15,000
Short term Investments	22	-	-	-	22
Accounts Receivable	31,069	(31,069)	-	-	-
Other Current Assets	7,667	(6,827)	-	-	840
Total Current Assets	65,253	112,104	(52,518)	(17,321)	107,518
Marketable Securities	20,451	-	-	-	20,451
Assets Whose Use is Limited					
By Donor and Held in Trust	15,881	-	-	-	15,881
For Estimated Self Insurance Liability	34,481	-	-	-	34,481
By Bond Indenture	5,768	-	-	(5,768)	-
Net interest in Foundation	5,114	-	-	-	5,114
Other	6	-	-	-	6
Total Assets Whose Use is Limited	61,250	-	-	(5,768)	55,482
Property, Plant, and Equipment	62,311	(62,311)	-	-	-
Investment in Joint Ventures	9,871	(9,671)	-	-	200
Deferred Financing Costs	111	-	-	(111)	-
Other Noncurrent Assets	-	-	-	-	-
Total Other Assets	9,982	(9,671)	-	(111)	200
Total Assets	$ 219,247	$ 40,122	$ (52,518)	$ (23,200)	$ 183,651

Net Proceeds Calculation Prepared By Management

Saint Mary's Health System ($ in thousands)	May 2014 Pre Close	Tenet Purchase	Fund Pension	Eliminate Debt	Saint Mary's Consolidated Post Close
Current Portion of Long Term Debt	$ 2,452		$ -	$ (2,452)	$ -
Accounts Payable	14,623	(14,623)	-	-	-
Accrued Payroll Expenses	4,499	(4,418)	(81)	-	-
Due to Third Parties	5,030	(291)	-	-	4,739
Accrued Other Expenses	16,485	(8,386)	-	(608)	7,491
Total Current Liabilities	43,089	(27,718)	(81)	(3,060)	12,230
Long Term Obligations	20,029		-	(20,029)	-
Estimated Self Insurance Liability	24,630	-	-	-	24,630
Accrued Compensation & Benefits	-	-	-	-	-
Unfunded Pension Liability	52,437	-	(52,437)	-	-
Other Long Term Liabilities	11,735	(2,954)	-	-	8,781
Total Long Term Liabilities	108,831	(2,954)	(52,437)	(20,029)	33,411
Unrestricted	48,185	70,918	-	(111)	118,992
Temporarily Restricted	2,269	(124)	-		2,145
Permanently Restricted	16,873	-	-		16,873
Total Net Assets	67,327	70,794	-	(111)	138,010
Total Liabilities and Fund Balance	$ 219,247	$ 40,122	$ (52,518)	$ (23,200)	$ 183,651

Net Proceeds Calculation Prepared By Management

Estimated Net Proceeds to the Foundation ($ in 000s)	
Purchase Price	$ 150,000
Plus/(Less): Working Capital Adjustment (1)	4,622
Less: Reduction of Pension Liability	(52,518)
Plus: Assets Retained by Saint Mary's (2)	109,308
Less: Liabilities Retained by Saint Mary's	(68,780)
Less: Indemnity Reserve Holdback	(15,000)
Estimated Net Proceeds to the Foundation (3)	**$ 127,632**

Note: As of the May 2014 balance sheet
(1) Minimum working capital requirement is $6.3 million, $4.6 million represents excess over $6.3 million.
(2) Assets are valued at fair market value except for SMHS' shares in Premier which are valued at cost.
(3) Certain of these funds in the Fundation are restricted (estimated at about $19.0 million which includes Hellman Trust of $15.9 million).

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion

In deriving our "Fairness Opinion", we considered the value of the assets transferred against the value of the benefits to be received from a financial point of view. While we recognize that all parties to the Transaction anticipate that the sale will enhance the quality and access to healthcare in the community, these factors are difficult to quantify economically and have only been incidentally factored into our conclusions.

In assessing the value of the assets transferred we considered the three traditional valuation methodologies: the Cost Approach, Market Approach, and Income Approach.

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion - Continued

In deriving our "Fairness Opinion" we have among other things:

- Visited the Saint Mary's Hospital site to describe and assess the overall condition of the physical assets and improvements (a complete site inspection was conducted in February 2012 and a brief inspection was performed in August 2014.;
- Been provided and reviewed certain available business and financial information relating to Saint Mary's that was provided by Saint Mary's management team, including audited financial statements for the fiscal years ended September 30, 2011, 2012, and 2013 and internally prepared financial statements for the period ended May 31, 2014;
- Been provided with and relied upon the forecast of operations for fiscal 2014 through fiscal 2017 prepared by Saint Mary's management as a Stand-Alone organization if the transaction does not occur;
- Reviewed the Draft Asset Purchase Agreement by and among Saint Mary's Health System, Inc., Saint Mary's Hospital, Inc., VHS of Connecticut, LLC, VHS Saint Mary's Health System, LLC, and Tenet Healthcare Corporation dated May 30, 2014;
- Reviewed minutes of the Board of Directors of Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc. for the period September 13, 2012 through May 22, 2014; reviewed Transaction Team minutes for the period June 3, 2011 through May 19, 2014;

(Continued)

Scope of Principle Valuation's Analysis to Arrive at Fairness Opinion - Continued

In deriving our "Fairness Opinion" we have among other things (continued):

- Reviewed the reports prepared by H2C, including the Board Discussion report dated as of June 19, 2014 and the Taskforce issues List and Transaction Risks report;
- Considered the criteria set forth in the Conversion Statute;
- Interviewed members of Saint Mary's management;
- Reviewed such other financial studies and analysis and took into account such other matters as we deemed necessary, including our assessment of general economic market and monetary conditions;
- Reviewed the historical market prices, trading activity and valuation multiples of certain publicly traded companies that we deemed to be relevant and used them as benchmarks to estimate relative criteria in our analysis; and
- Compared the proposed financial terms of the proposed purchase with certain other transactions that we deemed relevant.

Critical Facts and Assumptions

The following critical facts and assumptions among other factors were considered in deriving our overall estimates:

- Saint Mary's and REDACTED represent the two primary healthcare providers in the Greater Waterbury market area;
- In the absence of this transaction, Saint Mary's will face direct competition from Redacted and other nearby hospitals;
- Saint Mary's physical plant is in the later stages of its economic life and needs substantial renovations or replacement within the foreseeable future. Based upon a physical inspection, discussions with management, and the actual age and condition of the property, we have assigned a remaining economic life for the Saint Mary's Campus of five to seven years;
- It is anticipated by management that Saint Mary's earnings will continue to deteriorate due to the increased costs associated with its current operations to the point that within five years the overall business operations will be generating marginally positive cash flows;
- The current and foreseeable future earnings of Saint Mary's will continue to restrict them from accessing the capital needed to build a more modern efficient hospital facility or alternative delivery system;
- In the absence of this Transaction and in consideration of the factors stated above the overall economic viability of the organization and its ability to continue its Community Healthcare Benefits and Teaching mission may be in jeopardy beyond a five year time horizon;

Critical Facts and Assumptions - Continued

- Saint Mary's payor mix is heavily weighted toward Medicare and Medicaid with each representing 38% and 26%, respectively;
- In the absence of this transaction Saint Mary's would face increased competition in its area for physician resources with Tenet Healthcare and its purchases and affiliations with neighboring healthcare systems;
- In the absence of this transaction it would be anticipated that Saint Mary's would have limited access to alternative capital or lending sources;
- Saint Mary's has been investigating various offers over a two to three year period. Other offers include $101.1 million from IASIS Healthcare, $131.1 million from Health Management Associates, and $136.1 million from Community Health Systems. Saint Mary's strongly considered an offer from LHP Hospital Group which included cash of $108 million and a 20% ownership in the new organization.

Valuation of Assets Contributed - Overview

In deriving the value of the assets to be sold, we considered the three principal methods of valuation: the Cost Approach (Adjusted Book Value Approach), the Market Approach, and the Income Approach. Each Approach as applied to Saint Mary's is briefly explained below:

- In the Cost Approach, the tangible assets of Saint Mary's were valued by deriving a depreciated replacement cost for the tangible assets in use. The land was valued at its current value assuming current market data. The Net Working Capital was valued based upon the target working capital from the Asset Purchase Agreement. A Summary of this Approach is shown on Schedule A.

- In the Income Approach to Value, we considered the value of Saint Mary's utilizing a Discounted Cash Flow approach based upon market based cost of capital considerations and the anticipated earning capacity of Saint Mary's in a "Stand-Still" strategic choice. This analysis is shown in Schedule B.

- We considered two Market Based approaches in estimating the value of the subject; Guideline Company Approach and Guideline Transaction Approaches to value. These approaches are shown on Schedules C and D, respectively.

After considering the strengths and weakness of each approach, we derived an overall weighted value for the assets contributed.

Schedule A – Cost Approach Summary

SAINT MARY'S HOSPITAL
VALUATION SUMMARY AS OF AUGUST 15, 2014

Building/Property	Land Value	Building Depreciated Cost	Land Improvements Depreciated Cost	Total Real Estate Value	FF&E	Grand Total
St. Marys Hospital	$ 2,170,000	$ 59,654,010	$ 434,593	$ 62,258,603	$11,595,344	$ 73,853,947
Lawlor Building	-	209,127	-	209,127	-	209,127
Conference Center	-	3,312,975	-	3,312,975	-	3,312,975
Parking Garage (Employee)	-	5,864,534	-	5,864,534	-	5,864,534
Parking Garage (Visitor)	-	3,043,474	-	3,043,474	-	3,043,474
H. Leever Regional Cancer Center - 50% ownership	670,000	5,616,382	111,314	6,397,696	-	6,397,696
290 French Street	295,000	-	-	295,000	-	295,000
133 Scovill Street, 1-A	-	2,600,000	-	2,600,000	-	2,600,000
133 Scovill Street, 2-A	-	250,000	-	250,000	-	250,000
133 Scovill Street, 2-B	-	330,000	-	330,000	-	330,000
133 Scovill Street, 2-H	-	200,000	-	200,000	-	200,000
133 Scovill Street, 2-J	-	270,000	-	270,000	-	270,000
133 Scovill Street, 2-K	-	160,000	-	160,000	-	160,000
133 Scovill Street, 3-A	-	280,000	-	280,000	-	280,000
133 Scovill Street, 3-B	-	100,000	-	100,000	-	100,000
133 Scovill Street, 3-C	-	370,000	-	370,000	-	370,000
TOTALS	**$ 3,135,000**	**$ 82,260,503**	**$ 545,907**	**$ 85,941,411**	**$ 11,595,344**	**$ 97,536,755**

Schedule A – Cost Approach Summary - Continued

Asset Value Summary	
Land	$ 3,135,000
Land Improvements	545,907
Buildings	82,260,503
Working Capital	6,300,000
Equipment	11,595,344
Total Tangible Assets	**$ 103,836,755**
Rounded To	**$ 103,800,000**

Schedule B – DCF Stand Still

Discounted Cash Flow Saint Mary's Health System

		FYE September 30, 2013	FYE September 30, 2014 (1)	FY 2015 Projected	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected	FY 2019 Projected
Net Patient Service Revenue		$ 268,899,000	$ 274,669,000	$ 285,061,453	$ 288,205,477	$ 293,962,237	$ 301,311,293	$ 308,844,076
Less: Provision for Bad Debts		12,878,000	11,461,000	11,894,642	12,025,831	12,266,041	12,572,692	12,887,009
Net Patient Service Rev after Bad Debts		$ 256,021,000	$ 263,208,000	$ 273,166,812	$ 276,179,646	$ 281,696,196	$ 288,738,601	$ 295,957,066
Other Operating Revenue (2)		6,715,000	6,946,000	6,975,860	8,066,619	8,658,285	8,874,742	9,096,610
Revenue from Operations		$ 262,736,000	$ 270,154,000	$ 280,142,672	$ 284,246,265	$ 290,354,481	$ 297,613,343	$ 305,053,677
Growth			2.8%	3.7%	1.5%	2.1%	2.5%	2.5%
OPERATING EXPENSES								
Salaries and Wages	v	$ 108,933,000	$ 110,427,000	$ 115,542,461	$ 117,261,113	$ 119,005,328	$ 121,980,461	$ 125,029,973
Fringe Benefits	v	31,305,000	28,972,000	29,814,987	30,258,474	30,708,557	31,476,271	32,263,178
Physicians Fees	v	8,207,000	8,297,000	8,462,940	8,632,199	8,804,843	9,024,964	9,250,588
Supplies and Drugs	v	38,194,000	40,131,000	42,224,824	43,490,482	44,794,076	45,913,928	47,061,776
Malpractice Insurance Cost	f	8,292,000	6,358,000	6,485,160	6,614,863	6,747,160	6,915,839	7,088,735
Other Operating Expense	f	42,477,000	52,055,000	53,390,880	54,458,698	55,547,872	56,936,568	58,359,983
Lease Expense	f	6,145,000	6,082,000	6,203,640	6,327,713	6,454,267	6,615,624	6,781,014
Subtotal		243,553,000	252,322,000	262,124,893	267,043,540	272,062,103	278,863,656	285,835,247
Depreciation/Amortization	f	10,052,000	9,930,000	10,134,720	10,337,414	10,544,163	10,807,767	11,077,961
Interest Expense		1,598,000	1,465,000	1,392,300	1,318,146	1,242,509	1,273,572	1,305,411
Total Operating Expense		$ 255,203,000	$ 263,717,000	$ 273,651,913	$ 278,699,101	$ 283,848,775	$ 290,944,994	$ 298,218,619
Gain/(Loss) from Operations		$ 7,533,000	$ 6,437,000	$ 6,490,759	$ 5,547,164	$ 6,505,706	$ 6,668,349	$ 6,835,058
Non-Operating Revenue		1,758,000	1,256,000	2,046,120	2,087,042	2,128,783	2,182,003	2,236,553
Excess of revenue over expenses		$ 9,291,000	$ 7,693,000	$ 8,536,879	$ 7,634,206	$ 8,634,490	$ 8,850,352	$ 9,071,611
EBITDA (includes non-operating income)		$ 20,941,000	$ 19,088,000	$ 20,063,899	$ 19,289,767	$ 20,421,161	$ 20,931,690	$ 21,454,982
EBITDA Margin		*8.0%*	*7.1%*	*7.2%*	*6.8%*	*7.0%*	*7.0%*	*7.0%*
EBIT		$ 10,889,000	$ 9,158,000	$ 9,929,179	$ 8,952,352	$ 9,876,998	$ 10,123,923	$ 10,377,021

Note:
(1) 2014 represents actual results for the 8 months ended May 31, 2014 and projected 4 months.
EBITDA for the 8 months ended May 31, 2014 was $15,147,000.
(2) Other operating revenue excludes Meaningful Use revenue of the following:

2013	2014 (1)	FY 2015	FY 2016	FY 2017
$ 1,149,000	$ 2,840,000	$ 2,100,000	$ 1,100,000	$ 600,000

Schedule B – DCF Stand Still - Continued

Discounted Cash Flow Saint Mary's Health System					
Discount Rate	11.00%				
Effective Corporate Tax Rate in U.S, CT	39.88%				
Normal Debt Free Net Working Capital as % of Revenues	12.00%				
	FY 2015 Projected	FY 2016 Projected	FY 2017 Projected	FY 2018 Projected	FY 2019 Projected
NET INCOME FOR DISCOUNTING (EBIT)	$ 9,929,179	$ 8,952,352	$ 9,876,998	$ 10,123,923	$ 10,377,021
ESTIMATED INCOME TAXES	3,959,260	3,569,750	3,938,453	4,036,914	4,137,837
NET INCOME	**$ 5,969,919**	**$ 5,382,602**	**$ 5,938,545**	**$ 6,087,009**	**$ 6,239,184**
Less Incremental Working Capital	$ 1,198,641	$ 492,431	$ 732,986	$ 871,063	$ 892,840
Less Capital Expenditures	(10,000,000)	(10,000,000)	(10,000,000)	(10,000,000)	(10,000,000)
Plus Depreciation	10,134,720	10,337,414	10,544,163	10,807,767	11,077,961
Cash Flow to Discount	$ 7,303,280	$ 6,212,447	$ 7,215,694	$ 7,765,839	$ 8,209,985
Discount Periods	0.500	1.500	2.50	3.50	4.50
Present Value Factor	0.9492	0.8551	0.7704	0.6940	0.6252
Present Value of Periodic Cash Flows	$ 6,931,966	$ 5,312,247	$ 5,558,667	$ 5,389,618	$ 5,133,209
Sum of PV Periodic Cash Flows		$ 28,325,707			
Perpetuity Value	$ 150,184,877				
PV of Perpetuity Value		$ 93,901,558			
Business Enterprise Value Before Adjustments		**$ 122,227,265**			
Adjustments to Value:					
Less: Market Required Working Capital Balance		$ (32,418,480)			
Add: Target Net Working Capital Balance		6,300,000			
Excess/(Deficit) Working Capital		$ (26,118,480)			
Meaningful Use (ERIT)		$ 3,396,054			
Business Enterprise Value After Adjustments		**$ 99,504,839**			
Rounded Value		**$ 99,500,000**			

Schedule B – DCF Stand Still - Continued

DEVELOPMENT OF WACC - SAINT MARY'S HEALTH SYSTEM					
			Cost of Capital	% in Capital Structure	Weighted Cost
Debt			2.83%	50%	1.42%
Equity			19.85%	50%	9.93%
Weighted Average Cost of Capital					11.34%
Concluded WACC					**11.00%**
Cost of Equity					
Risk Free Rate of Return		3.05%			
Plus Equity Risk Premium					
Market Risk Premium[1]	5.00%				
Times Beta	1.76				
Adjusted Market Risk Premium		8.80%			
Plus Size Premium[2]		6.00%			
Plus Company Specific Risk Premium		2.0%			
Indicated Cost of Equity		**19.85%**			
Cost of Debt					
Concluded Pre-Tax Cost of Debt	4.70%				
Income Tax Rate	39.88%				
Concluded After-Tax Cost of Debt		**2.83%**			
Selected Yields and Interest Rates					
Rates as of 06/30/2014					
Prime Rate			3.25%		
5-Year Treasury Rates			1.54%		
10-Year Treasury Rates			2.48%		
20-year Treasury Rates			3.05%		
Moody's Aaa			4.16%		
Baa			4.70%		

(1) Long-horizon expected equity risk premium recommended by Duff & Phelps 2014 Valuation Handbook
(2)Estimated based on Duff & Phelps 2014 Valuation Handbook - Guide to Cost of Capital

Schedule C – Guideline Company Approach – Stand Still

Guideline Company Approach - Schedule C													
Company Name	Share Price 6/1/2014	Adjusted Equity Value[1]	Adjusted Enterprise Value	% Debt	Revenues	EBITDA	Debt Free NWC	% Debt Free NWC	Beta	EBITDA Margin	Revenue Multiple	EBITDA Multiple
Universal Health Services Inc. (UHS)	$ 89.57	10,626,943,080	14,149,122,080	25.96%	7,372,356,000	1,393,309,000	536,306,000	7.27%	1.82	18.90%	1.92	10.16
Tenet Healthcare Corp. (THC)	$ 47.00	5,507,460,000	16,867,460,000	70.43%	12,641,000,000	1,332,000,000	1,264,000,000	10.00%	1.63	10.54%	1.33	12.66
Community Health Systems, Inc. (CYH)	$ 41.77	5,640,453,720	23,853,453,720	74.18%	13,918,693,000	1,679,438,000	2,700,000,000	19.40%	1.82	12.07%	1.71	14.20
Health Management Associates, I (HMA)	$ 14.37	4,487,061,240	8,631,970,240	47.54%	5,842,690,000	724,830,000	721,142,000	12.34%	N/A	12.41%	1.48	11.91
HCA Holdings, Inc. (HCA)	$ 52.99	28,805,999,880	59,090,999,880	53.28%	34,574,000,000	6,676,000,000	4,027,000,000	11.65%	1.76	19.31%	1.71	8.85
Lifepoint Hospitals Inc. (LPNT)	$ 61.24	3,317,248,320	5,928,848,320	44.31%	3,754,400,000	589,100,000	1,033,700,000	27.53%	1.00	15.69%	1.58	10.06
HIGH:			$59,090,999,880	74.18%	$34,574,000,000			27.53%	1.82	19.31%	1.92	14.20
LOW:			$5,928,848,320	25.96%	$3,754,400,000			7.27%	1.00	10.54%	1.33	8.85
AVERAGE				52.62%				14.70%	1.61	14.82%	1.62	11.31
MEDIAN:				50.41%				12.00%	1.76	14.05%	1.64	11.03

(1) Adjusted upward 20% to account for a control premium

Qualitative Comparisons (Subject Compared to Market Comparables as a Group) St. Mary's 7.1%

Unit of Comparison	Status	Adjustment
Size of Company	Inferior	Downward
Diversity of Market Served	Inferior	Downward
EBITDA Margin	Inferior	Downward
Overall Adjustment	**Significantly Downward**	

Saint Mary's Health System		
Description	Revenues	EBITDA
Adjustment	-70%	-40%
Adjusted Multiple*	0.487	6.785
Subject Comparable Units	$ 270,154,000	$ 19,088,000
Value Indication	$ 131,470,662	$ 129,504,460
Weighting	25%	75%
Total Asset Value as Unencumbered and assuming market based working capital (Rounded)	$130,000,000	
Market Required Working Capital Balance	$ (32,418,480)	
Actual Working Capital Balance	$ 6,300,000	
Less Deficient (Excess) Working Capital	$ (26,118,480)	
Overall Value of Operating Business Enterprise (rounded)	$103,900,000	

Schedule D – Guideline Transaction Approach

Announcement Date	Seller	Number of Beds	Consideration	Revenue Multiple	EBITDA Multiple	Price/Bed	EBITDA Margin	EBITDA/Bed
01/02/13	Knapp Medical Center	209	$110,000,000	0.86	13.46	$526,316	6.4%	$39,113
02/03/13	Cancer Center at Metro Health Village	208	$6,200,000	N/A	N/A	$29,808	N/A	N/A
02/21/13	Emanuel Medical Center	354	$5,000,000	0.02	0.39	$14,124	6.1%	$36,211
03/08/13	Cleveland County HealthCare System	504	$101,000,000	0.45	4.08	$200,397	11.1%	$49,171
03/22/13	CharterCARE Health Partners	454	$95,000,000	N/A	N/A	$209,251	N/A	N/A
03/28/13	Two Kansas Hospitals	232	$54,300,000	0.29	N/A	$234,052	-4.8%	N/A
04/19/13	St. Luke's Episcopal Health System	1,098	$1,000,000,000	0.78	37.66	$910,747	2.1%	$24,180
06/23/13	Altoona Regional Health System	402	$10,000,000	0.03	0.16	$24,876	16.4%	$151,781
06/24/13	Vanguard Health Systems, Inc.	7,081	$4,300,000,000	0.72	12.05	$607,259	5.9%	$50,402
07/01/13	Physicians Specialty Hospital	20	$22,625,000	0.24	15.13	$1,131,250	1.6%	$74,758
07/11/13	Stanly Health Services	119	$70,000,000	0.67	4.96	$588,235	13.4%	$118,643
07/16/13	Verdugo Hills Hospital	158	$30,000,000	0.32	3.48	$189,873	9.3%	$54,513
07/18/13	3 IASIS Healthcare Hospitals	691	$146,000,000	0.63	9.24	$211,288	6.8%	$22,874
07/18/13	El Paso Surgical Center and MOB	40	$40,000,000	1.42	N/A	$1,000,000	N/A	N/A
07/30/13	Health Management Associates, Inc.	11,000	$7,600,000,000	1.30	10.82	$690,909	12.0%	$63,871
08/06/13	Portage Health	96	$40,000,000	0.49	4.41	$416,667	11.0%	$94,388
08/14/13	3 IASIS Healthcare hospitals	670	$283,300,000	N/A	N/A	$422,836	N/A	N/A
10/25/13	Oak Park Hospital	237	$21,100,000	0.20	9.22	$89,030	2.1%	$9,657
01/24/12	Memorial Health Systems	100	$45,000,000	0.46	6.34	$450,000	7.3%	$71,000
02/03/12	Integris Health joint venture	226	$60,000,000	N/A	N/A	$265,487	N/A	N/A
02/08/12	Cumberland River Hospital	36	$6,750,000	0.61	N/A	$187,500	N/A	N/A
02/28/12	Decatur General Hospital	242	$25,000,000	0.22	4.24	$103,306	5.2%	$24,380
03/01/12	Satilla Health Services	231	$51,000,000	0.33	12.14	$220,779	2.7%	$18,182
03/06/12	Marquette General Health System	307	$147,000,000	0.60	9.42	$478,827	6.4%	$50,814
03/09/12	Memorial Hospital and Convalescent Center	155	$8,300,000	N/A	N/A	$53,548	N/A	N/A
03/27/12	Christ Hospital	227	$43,500,000	0.35	31.07	$191,630	1.1%	$6,167
04/03/12	Bay Medical Center	323	$154,000,000	0.60	16.21	$476,780	3.7%	$29,412
04/04/12	New England Sinai Hospital	212	$37,000,000	0.50	N/A	$174,528	N/A	N/A
05/01/12	Auburn Regional Medical Center	159	$98,000,000	0.72	5.76	$616,352	12.6%	$106,918
06/01/12	Westerly Hospital	101	$69,000,000	0.76	11.96	$683,168	6.4%	$57,129
06/12/12	Jefferson Regional Medical Center	376	$275,000,000	1.34	12.17	$731,383	11.0%	$60,106
07/01/12	Fox Chase Cancer Center	100	$83,800,000	0.24	N/A	$838,000	N/A	N/A
07/02/12	Bakersfield Heart Hospital	47	$38,100,000	N/A	N/A	$810,638	N/A	N/A
08/27/12	Hawaii Medical Center - West Campus	102	$70,000,000	N/A	N/A	$686,275	N/A	N/A
10/19/12	St. Vincent's Health System	400	$65,000,000	0.20	4.24	$162,500	4.7%	$38,285
11/14/12	University of Louisville Hospital	345	$543,500,000	1.21	49.77	$1,575,362	2.4%	$31,650
11/15/12	Arkansas Surgical Hospital	51	$36,200,000	0.70	2.71	$709,804	26.0%	$261,817
12/05/12	South Hampton Community Hospital	111	$30,000,000	0.75	2.00	$270,270	37.5%	$135,135
12/10/12	Medical Center of Newark	20	$26,000,000	1.43	N/A	$1,300,000	-0.9%	N/A
12/13/12	New York Westchester Square Medical Center	140	$14,000,000	0.18	N/A	$100,000	-3.1%	N/A
12/15/11	Alamance Regional Medical Center	218	$200,000,000	1.12	8.47	$917,431	11.0%	$108,315
11/29/11	Health Central	177	$177,000,000	1.62	11.41	$1,000,000	11.8%	$87,642
09/29/11	Bay Medical Center	323	$155,000,000	0.71	16.31	$479,876	3.6%	$29,422
09/06/11	Mercy Hospital & Medical Center	449	$150,000,000	0.71	9.80	$334,076	6.0%	$34,089
09/01/11	Logan Medical Center	25	$7,200,000	0.38	7.20	$288,000	4.4%	$40,000
07/28/11	Tomball Regional Medical Center	358	$209,500,000	1.66	11.90	$585,196	11.6%	$49,176
07/19/11	Moses Taylor Health Care System	242	$152,000,000	1.22	16.00	$628,099	6.4%	$39,256
06/28/11	Southcrest Hospital, Claremore Regional	269	$154,200,000	0.98	5.12	$573,234	16.0%	$111,960
06/03/11	Person Memorial Hospital	102	$22,700,000	0.65	10.80	$222,549	5.0%	$20,606
04/27/11	Alexian Brothers Health System	752	$645,000,000	0.80	6.32	$857,713	10.6%	$135,714

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Schedule D – Guideline Transaction Approach - Continued

Announcement Date	Seller	Number of Beds	Consideration	Revenue Multiple	EBITDA Multiple	Price/Bed	EBITDA Margin	EBITDA/Bed
03/11/11	Hoopeston Regional Health Center	25	$12,400,000	0.72	8.85	$496,000	6.8%	$56,045
02/01/11	Hamot Medical Center	351	$300,000,000	1.14	9.09	$854,701	10.5%	$94,026
01/17/11	Johnston Memorial Hospital	25	$1,600,000	0.61	N/A	$64,000	N/A	N/A
10/03/11	Louisiana Medical Center & Heart Hospital	137	$23,000,000	0.55	N/A	$167,883	N/A	N/A
10/20/11	Cleveland Regional Medical Center	107	$68,500,000	1.43	N/A	$640,187	N/A	N/A
10/27/11	Twin County Regional Hospital	86	$37,500,000	1.02	N/A	$436,047	N/A	N/A
11/29/11	The Drake Center	166	$15,000,000	0.31	N/A	$90,361	N/A	N/A
12/12/11	MetroSouth Medical Center	244	$70,500,000	0.56	N/A	$288,934	N/A	N/A
04/20/11	Tri-Lakes Medical Center (95%)	112	$43,263,158	1.14	6.29	$386,278	15.1%	$61,411
05/15/11	UNC Healthcare System Rex Healthcare System	439	$750,000,000	N/A	N/A	$1,708,428	N/A	N/A
06/25/11	West Penn Allegheny Health System Inc	1,200	$1,500,000,000	N/A	N/A	$1,250,000	N/A	N/A
06/07/11	Lanmdark Medical Center, Wonsocket RI	214	$65,000,000	N/A	N/A	$303,738	N/A	N/A
05/31/11	Morton Hospital and Medical Center	119	$168,500,000	N/A	N/A	$1,415,966	N/A	N/A
05/13/11	Ameris Helath Systems LLC ; Smith Northview Hospi	29	$40,000,000	1.20	6.60	$1,379,310	15.2%	$208,986
05/12/11	Mercy Health Partners Knoxville (7 hospitals)	803	$525,000,000	1.08	N/A	$653,798	N/A	N/A
04/25/11	Hoboken University Medical Center	177	$91,700,000	0.96	N/A	$518,079	N/A	N/A
03/31/11	Texas Regional Medical Center	70	$62,700,000	N/A	N/A	$895,714	N/A	N/A
03/25/11	Hospital of Saint Raphael	423	$135,000,000	N/A	N/A	$319,149	N/A	N/A
03/22/11	St. Mary's Hospital Waterbury Connecticut	347	$135,000,000	N/A	N/A	$389,049	N/A	N/A
03/18/11	St. Joseph Medical Center Houston Texas (78.2%)	792	$210,997,442	N/A	N/A	$266,411	N/A	N/A
03/18/11	Cheyenne Regional Medical Center	217	$181,500,000	0.84	N/A	$836,406	N/A	N/A
02/23/11	Jackson Health System	2,482	$1,100,000,000	N/A	N/A	$443,191	N/A	N/A
02/08/11	Mercy Health Partners Scranton, PA	389	$150,000,000	0.68	12.57	$385,604	4.5%	$30,677
12/28/10	Riley Hospital	140	$24,000,000	0.50	20.00	$171,429	2.1%	$8,571
12/09/10	Two Essent Hospitals	179	$40,000,000	0.49	8.33	$223,464	4.9%	$26,826
11/19/10	Victor Valley Community Hospital	101	$37,000,000	0.84	11.90	$366,337	5.9%	$30,785
10/11/10	Long Island College Hospital	567	$110,000,000	N/A	N/A	$194,004	N/A	N/A
10/01/10	Pike County Memorial Hospital	32	$2,000,000	0.68	8.10	$62,500	7.0%	$7,716
09/16/10	St. Joseph's Hospital West VA	184	$87,000,000	1.08	N/A	$472,826	N/A	N/A
09/01/10	Univeristy Community Health	923	$355,000,000	0.84	N/A	$384,615	N/A	N/A
08/16/10	Fve Hospital in Southern California	759	$363,000,000	0.96	6.70	$478,261	11.9%	$71,382
08/02/10	Two Resurrection Hospitals in Chicago Suburbs	569	$45,000,000	0.20	N/A	$79,086	N/A	N/A
07/27/10	Wuesthoff Health System	413	$145,600,000	0.59	6.39	$352,542	7.7%	$55,171
06/17/10	Clinton Memorial Hospital	85	$82,137,477	0.95	11.73	$966,323	6.7%	$82,380
05/24/10	Coffee Health Group	517	$150,000,000	1.26	11.54	$290,135	9.1%	$25,142
04/15/10	USC University Hospital	471	$300,000,000	0.97	8.93	$636,943	9.1%	$71,326
04/09/10	Mountain View Hospital	43	$69,724,771	1.91	3.96	$1,621,506	40.2%	$409,471
04/05/10	Marion Regional Healthcare System	169	$28,300,000	0.58	3.93	$167,456	12.2%	$42,610
04/01/10	Clark Regional Medical Center	100	$60,000,000	1.34	15.79	$600,000	7.1%	$37,999
03/25/10	Caritas Christi Health	1,552	$830,000,000	0.76	15.29	$534,794	4.1%	$34,977
09/01/10	Wadley Regional Medical Center; Pikes Peak Hospit	385	$95,000,000	0.96	N/A	$246,753	N/A	N/A
11/18/10	North Country Health Services	118	$75,000,000	0.96	N/A	$635,593	N/A	N/A
			Low	0.02	0.16	$14,124	-4.8%	$6,167
			High	1.91	49.77	$1,708,428	40.2%	$409,471
			Mean	0.77	10.60	$512,424	8.6%	$68,375
			Median	0.72	9.15	$439,619	6.8%	$49,789

Note: The revenue multiples for 2011 and earlier were increased by 20% to adjust for the change in bad debt expense from an expense item to a contra-revenue item.

Schedule D – Guideline Transaction Approach - Continued

Transactions	Revenue Multiple	EBITDA Multiple	Price/Bed	EBITDA Margin	EBITDA/Bed
Low	0.02	0.16	$14,124	-4.8%	$6,167
High	1.91	49.77	$1,708,428	40.2%	$409,471
Mean	0.77	10.60	$512,424	8.6%	$68,375
Median	0.72	9.15	$439,619	6.8%	$49,789

St. Mary's - Projected FY 2014	Revenue	EBITDA	Beds	EBITDA Margin	EBITDA/Bed
FY 2014	$ 270,154,000	$ 19,088,000	347	7.1%	$ 55,009
Selected Multiple	0.50	7.00	$395,657		
Indications	$ 135,540,811	$133,616,000	$137,292,934		
Weights	25.0%	50.0%	25.0%		
Indicated Value				**$ 135,016,436**	
Plus: Working Capital				$ 6,300,000	
Overall Value (Rounded)				**$ 141,300,000**	

Overall Conclusion

The following table summarizes the value of the assets to be contributed and purchased against the benefits that Saint Mary's can reasonably anticipate to achieve given the assumptions and expectations associated with the proposed transaction as contained herein. Based upon a comparison of these economic expectations, it is our conclusion that the transaction is fair from a financial point of view as the value received is greater than the value of the assets contributed and purchased.

Saint Mary's Health System, Inc.
Summary and Conclusion
June 1, 2014

	Indicated Value	Weighting	Weighted Contribution
Adjusted Book Value Approach	$103,800,000	25%	$25,950,000
Discounted Cash Flow Approach	$99,500,000	25%	$24,875,000
Market Based Approaches			
Guideline Company Approach	$103,900,000	25%	$25,975,000
Guideline Transaction Approach	$141,300,000	25%	$35,325,000
Total Weighted Value of Assets Sold			**$112,100,000**

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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 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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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.

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.

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.

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)

See accompanying Notes to Consolidated Financial Statements.

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.

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.

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.

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.

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;

- 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.

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 61/4% 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.

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.

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.

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 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

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

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 91/4% 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 81/8% 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 81/8% 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 43/8% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 43/8% 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 87/8% 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 41/2% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 41/2% 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

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:

	Total	Years Ending December 31,					Later
		2014	2015	2016	2017	2018	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.

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.

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

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

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:

	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.

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	$ -	$ -

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**

	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:

	Total	Years Ending December 31, 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	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

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.

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.

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**

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

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.

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.

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.

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.

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

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.

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.

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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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, $0.05 par value; authorized 262,500,000 shares; 145,010,828 shares issued at June 30, 2014 and 144,057,351 shares issued at December 31, 2013	7	7
Additional paid- in capital	4,594	4,572
Accumulated other comprehensive loss	(20)	(24)
Accumulated deficit	(1,480)	(1,422)
Common stock in treasury, at cost, 47,196,972 shares at June 30, 2014 and 47,197,722 shares at December 31, 2013	(2,378)	(2,378)
Total shareholders' equity	**723**	**755**
Noncontrolling interests	**150**	**123**
Total equity	**873**	**878**
Total liabilities and equity	**$ 16,907**	**$ 16,130**

See accompanying Notes to Condensed Consolidated Financial Statements.

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.

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.

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)
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.

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.

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.

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**

	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,					Later
	Total	2014	2015	2016	2017	2018	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:

	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.

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 i San Antonio and South Texas markets;
- Our Florida region includes all of our hospitals and other operations in Florida;
- 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.

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:		
9⅞%, due 2014	$ 60	$ 60
9¼%, due 2015	474	474
5%, due 2019	1,100	0
6¾%, due 2020	300	300
8%, due 2020	750	750
8⅛%, due 2022	2,800	2,800
6⅞%, due 2031	430	430
Senior secured notes:		
6¼%, due 2018	1,041	1,041
4¾%, due 2020	500	500
6%, due 2020	1,800	1,800
4½%, due 2021	850	850
4⅜%, 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.

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.

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 91/4% 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.

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 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.

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

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	Accumulated Other		Treasury		
	Shares Outstanding	Issued Par Amount	Paid- in Capital	Comprehensive Loss	Accumulated Deficit	Stock	Noncontrolling Interests	Total Equity
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

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 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.

- *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.

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.

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			
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.

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

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.

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
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

	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 91/4% 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.

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 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.

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.

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 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.

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.

	Same- Hospital Continuing Operations Three Months Ended June 30,		
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.

Revenues	Same- Hospital Continuing Operations Three Months Ended June 30, 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 $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.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same- Hospital Continuing Operations Three Months Ended June 30, 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.

Provision for Doubtful Accounts	Same- Hospital Continuing Operations Three Months Ended June 30, 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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Selected Operating Expenses	Same- Hospital Continuing Operations Three Months Ended June 30, 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)			
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.

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;
- 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 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, 201
- An increase of $65 million in payments on reserves for restructuring charges, acquisition- related costs, and litigation costs and settlemen 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,		
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.

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 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:

	Three Months Ended June 30,		Six Months Ended June 30,	
Revenue Descriptions	**2014(1)**	**2013**	**2014(1)**	**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.

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:

	Six Months Ended June 30,			
	2014(1)		2013	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Michigan	$ 166	$ 125	$ -	$ -
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;

- 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.

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.

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);

- 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.

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 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

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**
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%
Paying visits (excludes	1,896,285	958,379	97.9%	3,678,724	1,902,928	93.3%

charity and uninsured)									
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.

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%
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.

Revenues	Same- Hospital Continuing Operations: Three Months Ended June 30, 2014	2013	Increase (Decrease)	Six Months Ended June 30, 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.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same- Hospital Continuing Operations: Three Months Ended June 30, 2014	2013	Increase (Decrease)	Six Months Ended June 30, 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.

Provision for Doubtful Accounts	Same- Hospital Continuing Operations: Three Months Ended June 30, 2014	2013	Increase (Decrease)	Six Months Ended June 30, 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.

Selected Operating Expenses	Same-Hospital Continuing Operations — Three Months Ended June 30, 2014	2013	Increase (Decrease)	Six Months Ended June 30, 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						
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.

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		
	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.

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%
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:

	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
- 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.

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 87/8% 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.

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 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 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.

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 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 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, 201:

- An increase of $65 million in payments on reserves for restructuring charges, acquisition- related costs, and litigation costs and settlemen 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.

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.

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.

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
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

) 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)*

1) 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

2) 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.

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)

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

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

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 O

BULK FILED

One hard copy of the Saint Mary's Foundation Binders was provided to the office of the Attorney General and one hard copy was provided to the Office of Health Care Access.

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June 6, 2013

VIA E-MAIL AND U.S. MAIL
ghammond@h2cllc.com

Greg Hammond
Hammond Hanlon & Camp
623 Fifth Avenue
29th Floor
New York, NY 10022

Re: Saint Mary's Hospital, Waterbury, CT

Dear Mr. Hammond:

is pleased to submit the following non-binding proposal to acquire the assets of Saint Mary's Hospital of Waterbury, Connecticut ("SMH"), as follows:

1. Transaction Structure

The transaction will be structured as an asset purchase with a subsidiary of acquiring the assets of SMH (the "Acquired Assets"). Except as otherwise provided for in a prospective Asset Purchase Agreement, the Acquired Assets will be transferred to Purchaser free and clear of all liens.

2. Liabilities

will not assume the long term liabilities (including the current portion of long term liabilities and any liabilities related to pension plans) but will assume the short term debt as included in the definition of net working capital.

3. Total Consideration

The total consideration to be paid for the Acquired Assets shall be within a range between Fifty Million Dollars ($50MM) to Eighty Million Dollars ($80MM), depending upon the results of due diligence review, plus estimated net working capital in cash paid at closing. There will be a true-up paid when the final net working capital calculation is made.

4. Financing

will finance the acquisition with cash on hand. Prime Healthcare's proposal is not subject to any financing contingency.

5. Timing

will commit to the following timetable:

(a) will complete any remaining due diligence within twenty-one (21) days of being notified that it has been selected as the successful bidder so long as it is provided full and complete access to additional information, if any, which may be requested by Prime Healthcare;

(b) will promptly negotiate the terms of a definitive agreement concurrently with the due diligence process and be prepared to execute a definitive agreement within twenty-one (21) days of being notified that it has been selected as the successful bidder; and

(c) will be prepared to close immediately upon receipt of regulatory approvals.

6. Sellers' Employees

will offer employment to substantially all of Sellers' employees effective as of the closing of a prospective Asset Purchase Agreement.

7. Charity Care

will commit to continue the provision of charity care services at SMH for at least five (5) years post-closing at levels no less than SMH's current levels of charity care.

8. Transaction Objectives

A transaction with will fulfill your transaction expectations because, among other things:

(a) has a proven track record of acquiring distressed community hospitals and turning them into successful community hospitals which provide quality care to all members of the community;

(b) mission is to provide comprehensive, quality healthcare in a convenient, compassionate, and cost-effective manner. As demonstrated by its success at several hospitals across the United States, Prime Healthcare accomplishes its mission by investing in the hospitals it acquires and developing collaborative relationships with employees, physicians, and the community;

(c) has a proven track record of providing high quality care as evidenced by Thomson Reuters ranking

in the Nation in 2009, a Top 15 Health System in the Nation in 20 , and a Top 15 health System in the Nation in 20

(d) is committed to the long term success of the hospitals it acquires as evidenced by its investment of more than $250 million for improvements at its hospitals over the past five (5) years and its conversion of five (5) of its hospitals into non-profit hospitals so as to better position these hospitals for long-term success;

(e) has strong financial resources and a long term track record of operating acute hospitals; and

(f) has a proven track record of closing transactions in a timely manner as evidenced by its acquisition of eighteen (18) hospitals in the last seven (7) years.

9. Overview of

is uniquely qualified to acquire and operate SMH as it has a proven track record of operating acute hospitals and more importantly, turning around hospitals into successful community hospitals which have received multiple accolades for quality of care.

A. Overview of

(a) Hospitals

The date of acquisition of each of these hospitals is as follows:

(b) Clinical Excellence

has a demonstrated track record of delivering high quality healthcare to all members of the community. currently operates acute care hospitals in different states (California, Texas, Pennsylvania, Nevada and Kansas) and the Foundation owns and operates acute care hospitals. Thomson Reuters, the world's leading source of intelligent information with more than 50,000 employees worldwide, ranked as one of the Top Health Systems in the United States for 2009 and one of the Top Health Systems in the Nation in 2011 and 2013. This accomplishment is especially remarkable when one considers that hospitals include one (that was in bankruptcy before came to

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its rescue and seven more

) that were near bankruptcy, in severe financial distress, in default on debt guaranteed by the State of ., and/or on the verge of closure before F acquired them. In addition to ranking as a Top Health System, (6 different times), r (3 different times),

have all been selected as Top 100 Hospitals by Thomson Reuters. The communities served by HRMC would be well served by having an entity like quire and operate This is especially true when one considers that, according to Thomson Reuters' report, more than 47,000 Medicare beneficiaries would survive each year and more than 92,000 patient complications would be avoided in the Medicare population if all hospitals performed like hospitals and the other members of the Top US Health Systems. Most recently, nine of hospitals were recognized as Top Performers on Key Quality Measures by Joint Commission.

In addition to high accolades from Thomson-Reuters, also has a track record of investing capital and improving patient care at each of the hospitals it has acquired and operates. For example, recently completed a $30 Million expansion which added 60 beds, operating rooms, and a cardiac surgery program to better serve the needs of the has embarked upon a $40 Million renovation project which will include an expansion of the emergency department, installed Cardiac Cath Labs at o better meet the needs of patients, and has purchased and installed new equipment and systems such as patient monitoring equipment, laboratory equipment, patient beds, and information systems at each of its hospitals so that patients receive better care. The net results of such investments as well as the dedication of each hospital's physicians and employees is that patients receive better care than before and receive such care in a much more efficient manner. For example, hospitals rarely, if ever, go on ambulance diversion, wait times in the emergency departments average twenty (20) minutes, and a patient's total stay in the emergency department lasts on average two hours.

will be dedicated to maintaining and growing the clinical programs at St. Mary's Hospital and look forward to working with local leadership to build upon the excellence that is currently in place.

(c) Key Executive Team

, Chairman - is a board certified r more than thirty years. is th and success and has unmatched experience managing hospitals and medical groups. y has been the recipient of various awards and has been ranked by Modern Healthcare as one of the most influential people in healthcare several times.

– **President, Hospital Operations** – has more than years of experience in healthcare including serving as a multi-hospital CEO, a multi-specialty medical group CEO, a hospital CFO, and in other senior executive and finance positions. Prior to joining was responsible for all hospital operations of F and also served as the CEO of

– **President, Hospital Operations II** – has been involved in hospital operations for the past ten (10) years and served as the Chief Executive Officer for
before being promoted to Chief Operating Officer. played a leading role in the successful acquisition of and presently serves on the Board of Directors of the

– Senior Vice-President, Development – has more than t of experience in healthcare operations and development and has served as CEO for several large hospitals throughout his career.

B. Contact Information

Please note that this letter sets forth the terms on which 's willing to acquire SMH and related assets and is not an offer capable of acceptance and does not constitute an enforceable agreement.

Sincerely,

March 20, 2013

CONFIDENTIAL – VIA ELECTRONIC MAIL

Chad Wable
President and CEO
St. Mary's Hospital
56 Franklin Street
Waterbury, CT 06706

Michael Hammond
H2C Hammond Hanlon Camp LLC
623 Fifth Avenue, 29th Floor
New York, NY 10022

Gentlemen:

This letter is being provided as a follow-up to my March 19th conversation with Chad concerning the terms of our revised offer for the purchase of substantially all of the assets of St. Mary's Health System ("St. Mary's").

As you know, foresees the establishment of a Catholic, for-profit integrated delivery system that would provide comprehensive healthcare across a continuum of services in the State of Connecticut. While foresees St. Mary's as being a strategic part of such a delivery system, to achieve ultimate objective it will be critical for to first consummate the acquisition of substantially all of the assets of and its associated businesses.

As consideration for acquisition of substantially all of the assets of St. Mary's, based upon due diligence furnished to to date, (or its affiliate) would (a) cause to assume St. Mary's pension plan liabilities, including any underfunded liabilities which estimates at $79,000,000, (b) assume liabilities arising after closing under St. Mary's contracts and leases that are set forth in the definitive agreements, (c) assume (and acquire) all net working capital items on St. Mary's balance sheet and (d) during the five (5) year period following closing, fund or commit to fund no less than $50,000,000 in the aggregate in capital expenditures for (i) ongoing maintenance, (ii) capital expenditures to support operational and business development priorities of the St. Mary's facilities, including capital expenses related to clinical information systems and the expansion of clinical services, and (iii) strategic capital requirements, including to improve the St. Mary's facilities and to expand services offered by the St. Mary's facilities in the communities surrounding the hospital.

The foregoing represents total consideration of approximately $129,000,000. Such total represents an amount equal to (a) 0.5 times St. Mary's revenue and (b) a multiple of twelve times EBITDA (before approximately $3,600,000 in Medicaid reductions, the details of which we have previously discussed).

Conditions to the closing of a transaction would consist of (a) having consummated the Saint Francis transaction, (b) having received confirmation that it will obtain property tax abatements for the St. Mary's real and personal property in an amount satisfactory to and (c) the following conditions set forth in previous draft of the Asset Purchase Agreement: (i) Representations and

Warranties/Covenants, (ii) Pre-Closing Confirmations, (iii) Title Policy, (iv) Actions/Proceedings, (v) Adverse Change, (vi) Insolvency, (vii) Opinion of Counsel to Seller, (viii) Required Consents and Approvals, (ix) Vesting/Recordation, (x) Closing Documents, (xi) Deposit Account Transfer Agreement, (xii) Employment Agreement and (xiii) Saint Mary's Hospital Foundation Guaranty.

Of course, this letter represents a non-binding proposal and no agreement will exist between the parties unless and until definitive agreements are executed. Each party reserves the right to withdraw from this transaction at any time for any reason without liability or obligation.

greatly appreciates this opportunity and hopes that St. Mary's finds the foregoing terms acceptable such that the parties can continue moving forward.

Sincerely,

Q

VERBATIM PROCEEDINGS

SAINT MARY'S HOSPITAL

PUBLIC HEARING

PROPOSED TRANSACTION BETWEEN SAINT MARY'S HEALTH SYSTEM
AND TENET HEALTHCARE CORPORATION

JULY 28, 2014

SAINT MARY'S HOSPITAL
56 FRANKLIN STREET
WATERBURY, CT 06706

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

1 . . .Verbatim proceedings of a hearing in
2 the matter of a proposed transaction between Saint Mary's
3 Health System and Tenet Healthcare Corporation, held at
4 Saint Mary's Hospital, 56 Franklin Street, Waterbury,
5 Connecticut, on July 28, 2014 at 5:00 p.m. . . .
6
7
8
9 MAYOR NEIL O'LEARY: So I've been asked to
10 open this up today, and I'm honored and feel very
11 privileged to be able to do so.
12 I know that there's a bunch of great
13 people here that have a lot of things to say to you, and,
14 certainly, they're all very important.
15 I will tell you right now I'm going to
16 have to excuse myself. I'm actually going to walk across
17 the way to the E.R. I have a family member there, so I'm
18 going to have to go visit her as soon as I get done
19 talking. Lucky for you guys I'm going to stop talking
20 quickly.
21 But I do want to just say a couple of
22 things. I have worked very, very hard with Tenet, in
23 particular, Mr. Pilgrim, who will be addressing you here
24 today, and several members of his staff.

1 I actually flew down to Dallas and met
2 with the Vice President, Mr. Keith Pitts, who I was very
3 comfortable in talking to.
4 I've also talked to the Archbishop as
5 recently as Saturday about this acquisition that's going
6 on here, and, from my point of view, you know, as the
7 Mayor of the City of Waterbury, what's most important for
8 me, obviously, is what's most important for the City and
9 the region.
10 And, of course, the health care world is
11 ever-changing as we speak, and I'm not a health care
12 administrator, and, quite frankly, I'm kind of glad I'm
13 not right now, because it's so complicated.
14 From my perspective, it changes just about
15 daily, and I'm glad these experts are here today to talk
16 to you and hopefully set some of your anxious moments at
17 ease.
18 Certainly, this is a big issue, right?
19 Going from a not-for-profit hospital to for-profit, going
20 from a local governance to a major corporation we
21 understand.
22 And I have to tell you that I've struggled
23 with this from the beginning, I really have, so I've
24 spent a lot of time trying to research and try to do and

1 get as much information as I can, so that I can
2 understand what the impacts would be on this community,
3 and I can tell you here, and I can stand in front of you
4 slightly anxious still, by the way, and I guess always
5 will be, but I feel comfortable telling you that I think
6 that this company, Tenet, is just a phenomenal company
7 that is going to bring healthcare into the Greater
8 Waterbury area to where it needs to go.
9 And I believe, honestly, that, with their
10 experience of running 79 hospitals and 180 or so acute
11 urgent care facilities, these people know what they're
12 doing, and they know how to operate in such a way that we
13 keep the most important things important to us, like the
14 safety net for our less privileged population here in the
15 City of Waterbury.
16 And I visited St. Vincent's Hospital,
17 which Tenet runs, in Worcester, Massachusetts and talked
18 to the staff there and have been assured repeatedly that
19 Tenet has just been a great partner for them and have
20 brought health care to a different level in Worcester,
21 Massachusetts.
22 And we've done the research across the
23 country through the Archdiocese of Hartford and making
24 sure that every Tenet-run hospital in any Archdiocese

1 across the country, and the report card is very, very
2 strong, straight As, if you will, and, so, we feel
3 comfortable about that, and the Archbishop is
4 comfortable. He feels comfortable that we're going in
5 the direction that we need to go to make sure that this
6 hospital is going to be where it should be two years,
7 five years, 10 years down the road and will be healthy.
8 So I'm very delighted to be here. I'm
9 glad to see all of you here. I'm certainly happy to see
10 Representative Noujaim here, and the President of our
11 Board of Alderman, Paul Pernerewski, is here.
12 These are the folks, who are governing
13 every day, and I know that they're anxious to hear what
14 everyone here has to say today, so I'm going to turn it
15 over now to Mr. Joe Connolly, who is the Vice President
16 of Community Affairs here at Saint Mary's, and, again,
17 apologize to you for having to leave, but my Chief of
18 Staff, Kevin DelGobbo, is here, and any questions that
19 come up on a local level Kevin will either answer them or
20 we will together work on them and get answers to you.
21 Please, please, feel free to call our
22 office if you have any concerns about what you hear
23 today. Feel free to call my office, and if we don't have
24 the answers for you, we will get them for you. I promise

1 you that.
2 So, without further ado, Mr. Connolly,
3 thank you, all, very, very much. (Applause)
4 SPEAKER JOSEPH CONNOLLY: Thank you, Mayor
5 O'Leary, and welcome, everybody.
6 Saint Mary's is pleased to hold this
7 public hearing regarding our proposed transaction with
8 Tenet Healthcare Corporation.
9 The hearing is intended to provide
10 information about the proposed transaction contained in
11 the Certificate of Need determination letter that was
12 filed with both the Attorney General and the Department
13 of Public Health, Office of Health Care Access, on July
14 9th.
15 Our agenda for this evening will be as
16 follows. I'm going to take a few minutes to walk you
17 through the purpose of the hearing, the statutory
18 requirements that we believe apply to our proposal, and
19 let you know the format for your participation in the
20 meeting in a little while.
21 I'll be followed by Mr. Bob Mazaika, who
22 is the Chairman of Saint Mary's Health System Board of
23 Directors and a Board Task Force, and Bob will review our
24 affiliation process and the guidelines, the guidelines of

1 affiliation that we follow throughout that process.
2 Mr. Mazaika will be followed by Chad
3 Wable, our President and CEO, who will provide
4 information regarding the health care environment and the
5 factors that went into our decision and the rationale
6 behind our decision to pursue this transaction with
7 Tenet.
8 Attorney Bob Anthony, who is the Saint
9 Mary's legal counsel, will present highlights of the
10 proposed transaction, and Dr. Bob Gumbardo will present
11 the perspective of the medical staff.
12 Following those speakers, we'll open it up
13 for public comments, questions and answers, and we'll
14 have a panel at the front that will be available for you
15 during that part of the meeting.
16 Before we get started, there are a few
17 guidelines for the public comment part of the meeting
18 that I'd like to review.
19 Tonight's hearing is being conducted in
20 accordance with the changes to the CON statute, and we
21 want to conduct the hearing in as precise a manner as
22 possible.
23 So, as I just outlined, we have about 45
24 minutes or so, 45 to 60 minutes maybe of presentations

1 before we open the floor to questions or comments to
2 address this proposed transaction.
3 This hearing is a legal requirement for
4 the State regulatory process, so the presentation and the
5 questions and answers are being recorded, transcribed,
6 and they'll be submitted to the State of Connecticut,
7 Department of Public Health and the Office of Health Care
8 Access, as well as the Office of the Attorney General.
9 So if you'd like to speak, you must sign
10 in at the back of the room, and, if you haven't signed in
11 yet, you can make your way back there at any time during
12 the evening. We have plenty of staff back there.
13 When we come up to the time where it's
14 time to speak, I'll call you to the front, I'll call your
15 name to the microphone, and ask that you state your name
16 and the city where you reside before you begin speaking.
17 That's the microphone that we'll use for questions and
18 public comment later on in the meeting.
19 In deference to anyone, who might want to
20 speak, we ask that all of our speakers limit their
21 participation to one trip to the microphone, and, if you
22 can keep your comments to five minutes or less, I think
23 we'd all be very appreciative.
24 Again, everything will be transcribed and

1 submitted to the State as we go along.

2 If anyone would like to see the letter of
3 determination that this is based on, it is available both
4 on the State website, as well as on Saint Mary's website,
5 so if you want to refer to that document after the fact,
6 it is available to you.

7 Okay, so, our focus this evening is the
8 proposed transaction for the transfer of assets of Saint
9 Mary's Health System to the Tenet Healthcare Corporation.

10 The first step in this process is the
11 filing of a letter of determination. Within 30 days of
12 filing the letter of determination, the non-profit
13 hospital and the proposed purchaser must hold a public
14 hearing on the contents of the letter of determination,
15 which is why we're here this evening.

16 Again, this evening's hearing is being
17 recorded and transcribed, as required. We'll take the
18 recording of the transcription -- we'll take that
19 recording and make it available to the Commissioner of
20 OHCA, the Attorney General, and members of the public,
21 upon request.

22 The Commissioner and the Attorney General
23 will review the letter of determination. It's the
24 Attorney General who determines whether the statute for

1 the transaction requires approval under the so-called
2 Conversion Statute as a conversion from a non-profit to a
3 for-profit company. A joint review process is then
4 undertaken by the Commissioner and the Attorney General.
5 The Certificate of Need approval process
6 for hospital conversions is governed by Connecticut law.
7 The law contains standards that the Attorney General and
8 the Commissioner of Public Health must apply in rendering
9 a decision for each application.
10 The law also allows for each agency to
11 engage experts to assist the Certificate of Need process.
12 The statute states that the Attorney General shall deny
13 an application that's not in the public interest if the
14 transaction is prohibited by Connecticut statutory or
15 common law governing non-profit entities, trusts, or
16 charities, if the Applicant fails to exercise due
17 diligence in deciding to transfer its assets, selecting
18 the purchaser, obtaining a fairness evaluation, or
19 negotiating the terms and conditions for the sale.
20 If the non-profit hospital fails to
21 disclose any conflict of interest, the application shall
22 be denied, and if the non-profit hospital would not
23 receive fair market value for its assets, the application
24 will also be denied.

1 By statute, the Public Health Commissioner
2 must also apply standards in reviewing and ruling on the
3 application. The Commissioner must deny an application,
4 unless the community will be assured of continued access
5 to high-quality affordable care.
6 The Commissioner must deny an application,
7 unless a commitment has been made to provide the care to
8 the uninsured and underinsured.
9 The proposal will also be reviewed under
10 standard Certificate of Need guidelines, including public
11 need, the impact on the financial strength of the health
12 care system in the state, whether the proposal will
13 improve quality, accessibility and cost effectiveness of
14 the health care delivery system in the region. So those
15 are the requirements that we're faced.
16 So, finally, a brief overview of the
17 potential timeline for this process. Please keep in mind
18 that these are our best estimates, based upon the
19 statutes and our expectation of what might happen, and
20 this timeline is certainly subject to change.
21 The process began with the filing of a
22 letter of determination, which was done on July 9th, and,
23 within 30 days, we're required to hold a public hearing,
24 which, again, is the purpose for this evening's meeting.

1 We expect that the Attorney General will
2 rule that our proposed transaction is, indeed, subject to
3 the conversion statute, and we anticipate that we'll
4 receive an application from the Attorney General and the
5 Office of Health Care Access shortly.
6 We'll, then, have 60 days in which to
7 complete that application. The State will hold
8 additional hearings once the application is deemed
9 complete and has a total of 120 days in which to render a
10 decision, however, it is also possible that we may have a
11 decision by the end of 2014. So that's the process.
12 I would now like to introduce the Chairman
13 of Saint Mary's Health System and Saint Mary's Hospital
14 Board of Directors, Mr. Bob Mazaika. Mr. Mazaika is
15 going to walk us through the selection process and the
16 principals of affiliation that have guided Saint Mary's
17 so far.
18 MR. ROBERT MAZAIKA: Thank you, Joe. Our
19 affiliation process, we've had an affiliation strategy
20 that's been in place for more than 10 years. We've had
21 extensive planning and discussions and due diligence done
22 at looking at a local affiliation, and that was completed
23 several years ago.
24 The most recent Board Task Force has been

1 in place for nearly five years, and we developed guiding
2 principals of affiliation that were developed and adopted
3 and approved by the Archbishop of Hartford.
4 More than 20 hospitals and health systems
5 have been contacted. They were both local and national
6 and not-for-profit and for-profit, and they were both
7 Catholic and secular.
8 Our proposed joint venture with LHP
9 Hospital Group was terminated in 2012, and our most
10 recent round of discussions included in-depth processes
11 with several finalist health systems before Tenet was
12 ultimately selected.
13 All our discussions have been evaluated,
14 and the decisions we've made have been made in the
15 context of the specific guiding principals of
16 affiliation, which I'll discuss in a little while.
17 In 2002, our affiliation process began,
18 and, in 2003, as part of our five-year strategic plan, we
19 adopted an affiliation strategy.
20 In 2004, a local affiliation work group
21 was formed to explore local affiliation options, and, in
22 2006, we solicited local and national not-for-profit
23 hospital and health systems.
24 In 2009, after long discussions, Saint

1 Mary's and Waterbury Hospital were not able to reach
2 suitable terms, and Saint Mary's developed future plans
3 as a standalone entity, while still consideration of
4 affiliation options.
5 In 2010, the present Board Task Force was
6 formed. We contacted 19 potential strategic partners,
7 and four finalist firms were selected.
8 We signed a letter of intent with HMA, and
9 Saint Mary's terminated the LOI in December of that year.
10 And, in 2011, we signed an LOI with LHP Hospital Group,
11 and, at that time, Waterbury Hospital agrees to enter the
12 proposed joint venture, and, in 2012, LHP terminates
13 discussions regarding the proposed joint venture.
14 In 2013, Saint Mary's begins new
15 discussions with multiple partners, both local and
16 national, and we explored significantly a potential
17 Catholic affiliation with Ascension Health Care Network.
18 We, then, identified several finalist
19 firms, and, in June of this year, we selected Tenet as
20 our preferred partner.
21 Let me get into now the guiding principals
22 of affiliation. From a philosophical point of view, we
23 wanted to make sure that we would continue to fulfill our
24 community-based mission. We wanted to improve the

1 delivery of quality care, and we wanted to make sure that
2 we would adhere to the ethical and religious directives
3 and secure our Catholic identity.
4 We wanted to maintain local governance and
5 provide locally-based health care as part of a regional
6 or a national health care delivery system, and we wanted
7 to enhance our current position as a charitable health
8 system and a hospital while being open to all possible
9 structures to best serve the interest of Saint Mary's and
10 our community.
11 From a financial point of view, we wanted
12 to prove the net asset value of Saint Mary's. We wanted
13 to approve access to and cost of capital. Running a
14 health care system is very capital-intensive.
15 We wanted to fully satisfy our unfunded
16 pension liability and secure the pensions that we
17 guaranteed our past employees.
18 We wanted to improve opportunities to
19 reduce costs, by creating efficiencies and economies of
20 scale, and we wanted to improve our revenue cycle
21 opportunities.
22 From a strategic point of view, we wanted
23 to acquire the necessary capital to sufficiently address
24 our capital needs. We wanted to improve our market

1 position and improve our technology and the overall
2 standard of care for our patients, and we wanted to
3 provide a regional or national scale leverage and
4 resources to address health reform requirements, which
5 Chad will be talking about a little bit later.
6 And we wanted to.improve future
7 opportunities to regionalize the Waterbury health care
8 delivery system, much as we did with the Heart Center and
9 the Cancer Center.
10 From our people point of view, we wanted
11 to improve our ability to meet our obligations to our
12 staff, not only those in the present, but those in the
13 past that served us and those that will serve us in the
14 future.
15 We wanted to improve recruitment and
16 retention of talent in the Greater Waterbury area, and we
17 wanted to create opportunities to strengthen partnerships
18 with our medical staff.
19 Tenet, who we chose in June, you can see
20 is a national health care system. It runs 79 hospitals,
21 193 outpatient centers, and they truly are from coast-to-
22 coast a national health care system.
23 Why do we feel confident that they will
24 keep us Catholic? They've had a tremendous Catholic

1 hospital experience. They run four Catholic hospitals.
2 The Mayor said that he visited St. Vincent Hospital.
3 Myself and my task force also visited St. Vincent
4 Hospital.
5 Archbishop Blair called the Archbishop of
6 Worcester and got a very nice report from Archbishop of
7 Worcester on how well they have protected the Catholic
8 identity of St. Vincent's.
9 They run Saint Mary's Medical Center in
10 West Palm Beach, Florida, and they continue to run their
11 ERDs and the Catholic system, so we feel very, very
12 confident that Saint Mary's will continue to be a
13 Catholic health care system in the Waterbury area.
14 Now I'd like to introduce Chad Wable,
15 President and CEO of Saint Mary's Health System. Chad?
16 MR. CHAD WABLE: Thank you, Bob. I want
17 to echo my colleagues by saying welcome to Saint Mary's.
18 Some of you, this may be your first time, so welcome to
19 Saint Mary's.
20 Saint Mary's is a very special place for
21 me. I want to thank you all for your interest here this
22 evening in this proposed transaction, your interest in
23 health care, your interest in health, and, really, your
24 interest in the local health care delivery system.

1 As I said, Saint Mary's is a special place
2 for me. All six of my children were born here at Saint
3 Mary's, so not just as an Administrator, but as a citizen
4 here, as someone, who seeks Saint Mary's for services,
5 this is important.
6 This is an important transaction for me,
7 for the community, for all of you here, and I appreciate
8 your support and your interest, and, hopefully, you'll
9 find that we're going to answer many of your questions
10 that you may have this evening.
11 So, with that, I'm going to talk a little
12 bit about the health care landscape and maybe help
13 understand a little bit of the rationale behind why
14 Tenet. Why did we select Tenet Healthcare Corporation?
15 So hospitals are in this great time of
16 change and transition. As I have discussions with many
17 of the 5,700 hospital administrators across the country,
18 they're all experiencing great change, lots of
19 transition.
20 I haven't had one discussion with one of
21 them that hasn't said there hasn't been a stretch of
22 period where we, as hospitals, haven't experienced more
23 change than they've ever seen.
24 We are certainly in transition, trying to

1 move from a model of care today that's going to be very
2 different in the future that I will soon talk about. I
3 will tell you that this change is certainly something
4 that, again, Saint Mary's, we're not experiencing alone.
5 Tenet has 79 hospitals. They're all
6 experiencing change. They can speak to that and all the
7 changes that are occurring, again, from coast-to-coast at
8 the Tenet hospitals.
9 My father-in-law is an OB-GYN in Fairmont,
10 West Virginia. His hospital is being acquired by a
11 national firm out of California. I talked to him about
12 the immense changes that he experiences not just as a
13 physician, but, also, the experience that he experiences.
14 He's on the Board of Directors of that hospital.
15 So, again, we're all experiencing change,
16 lots of change, lots of transition. We all love
17 progress, but, many times, we don't like change, and, so,
18 I view change as an opportunity, and I think this is
19 really an opportunity for Saint Mary's Health System to
20 really thrive in the future.
21 So I'll talk about two elements of change.
22 One is the economics, and two is the health care delivery
23 system. In terms of the economics, there's been
24 accelerated funding reductions across the country.

1 There's less access to capital, capital
2 costs more, and we have less capital, in general, in the
3 industry, so hospitals, again, are very capital-
4 intensive. We have a lot of fixed costs. We have a lot
5 of needs, so it's important that we service those needs.
6 The health care delivery system we're
7 going to be changing here to what's called Population
8 Health Management. Many of you may have read about that
9 new buzz word that's out there.
10 We're going to be moving from a delivery
11 system now, where the more that we do, the more that we
12 get paid, to a system where we're going to be trying to
13 keep people healthy, keep people out of the hospital, be
14 proactive versus reactive, a different health care
15 delivery system.
16 That health care delivery system is going
17 to need to have physicians, hospitals, other providers
18 aligned and working together like we've never worked
19 together before, and it's going to be a continuum of care
20 that we're looking at, not just acute care hospital
21 medicine, not when you get sick and have to go to the
22 Emergency Department, but before you get sick, after you
23 get sick, the whole continuum and all of those providers
24 finally working together in a much more cohesive and

1 aligned manner.
2 So one example of the funding reductions
3 is in Medicare. Medicare is projecting to reduce funding
4 to hospitals by 260 million dollars over the next 10
5 years.
6 If you're in the State of Connecticut, the
7 Medicaid system here in the State of Connecticut
8 reimburses hospitals somewhere between 60 and 70 cents
9 for every dollar of service that's delivered.
10 So when you have funding reductions by
11 Medicare that are already projected well into the future
12 for 10 years that are going to continue year, after year,
13 after year, you have a system of Medicaid that is going
14 to pay 60 to 70 cents on the dollar for care that's
15 provided.
16 In a commercial insurance market that is
17 continuing to develop new models of care in restricting
18 funding to all providers, it's going to require a need
19 for us to be part of a larger national system.
20 When you look at one of the big three
21 credit rating agencies, Moody's, Moody's Investor
22 Services, they basically, you know, look at the credit
23 worthiness of businesses, so Moody's, for the past two
24 years, have said that U.S. not-for-profit hospitals'

1 outlook remains negative, and then they cite revenue
2 growth to decline, but then they go on to say that the
3 sector, as a whole, will face weakening business
4 conditions and contracting margins as not-for-profit
5 hospitals adjust the changing dynamics brought on by the
6 Affordable Care Act.
7 We cannot afford in our industry to have
8 weakening business conditions. This is an industry,
9 where we save lives. There are wonderful things that
10 happen in hospitals every day, where we save a life, or
11 we bring a baby to life, or we do these amazing things,
12 and we cannot have a business sector that has weakening
13 business conditions and contracting margins. That's not
14 how you fund clinical technology. That's not a way to be
15 progressive as a hospital.
16 So hospitals will transition to what we
17 call value, so hospitals are moving from a business
18 model, where, again, the more that we do, the more we get
19 paid, and that's the current business model that we're
20 in, and that's been the business model for many, many
21 years, and that will continue to be the business model
22 for the next several years, however, we're in transition
23 as we move to a model where we're actually going to try
24 to keep people healthy, be proactive, and keep people out

1 of the hospital.
2 And as hard as it is for you to wrap your
3 heads around that notion, it's hard for us to wrap our
4 heads around that notion. It takes lots of people
5 working together, lots of expertise, lots of experience,
6 to which Tenet can bring, for us to wrap our heads around
7 how do we transition to a new business model?
8 Cost is going to be a major factor as we
9 move forward. We're all concerned to some degree about
10 the cost of health care.
11 I think, as we take more responsibility
12 for the cost of health care as consumers of health care,
13 the decision making is going to change.
14 We know right now that there's a
15 difference in the cost, for instance, of a colonoscopy.
16 You can pay $1,000 for a colonoscopy and probably $22,500
17 for a colonoscopy in the State of Connecticut.
18 If you had a high deductible insurance
19 plan, which those are increasing by the way, many of you
20 in this room may have those, you're going to make
21 decisions differently about which one of those you get.
22 You may travel.
23 So it's going to be very important that we
24 continue to understand the cost and quality of health

1 care. And then we move away from this notion of just
2 volume, the more we do, the more we get, to this notion
3 where we really get rewarded as a health care system for
4 cost and quality, for efficiency, for productivity, for
5 being a really good hospital, like we are here at Saint
6 Mary's Hospital.
7 So the question that we've been grappling
8 with, many of the 5,700 hospitals across the nation
9 grapple with, is this notion of can independent hospitals
10 survive?
11 As I've talked to independent hospitals
12 across the country, all of them are trying to figure out
13 can we really survive without being part of a large
14 national health care system? Can we truly deal with all
15 of these amazing trends, the reductions in funding, the
16 need for capital? Can we do all that and still remain
17 independent alone on an island by yourself?
18 I think that there's a lot of hospitals,
19 quite frankly, that can survive, but the question is do
20 you want your hospital to survive, or do you want your
21 hospital to thrive, and I think we want our hospitals to
22 thrive.
23 These are places, where, again, we save
24 lives, where, when you're at your sickest moments, you

1 want us to be there to take care of you, and we want to
2 be there to service your needs and have all of the
3 resources available to do that here in this community,
4 and, so, we want hospitals to thrive, not survive.
5 And it's not necessarily about the bricks
6 and mortar that's on the slide across the continuum of
7 care. That's important. It's who can attract the most
8 talented people, because it's about people. It's about a
9 physician that makes a clinical decision.
10 It's about a nurse that administers some
11 medications, and we want the best and brightest of those,
12 and we want to attract the best and brightest of those
13 here to Saint Mary's Hospital, and can an independent
14 hospital attract the best and brightest talent?
15 If you're a cardiothoracic surgeon and
16 you're graduating from your training right now and you're
17 trying to select where you're going to go, what hospital
18 you're going to go and associate with, are you going to
19 associate with the independent hospital that might have
20 resources available that might not be sustainable, or are
21 you going to select a hospital that has multiple
22 resources, a system of care wrapped around it?
23 Predictability, sustainability. Same
24 applies for the nurse. The same applies for every other

1 physician and health care professional that's out there.
2 We want the best.
3 The American Hospital Association confirms
4 the need for large hospital networks. They go on in this
5 to say that there's must-do strategies for hospitals in
6 the future. This is the American Hospital Association.
7 Number one, aligning hospitals' physicians
8 and other providers across the continuum of care. Two,
9 utilizing the evidence-based practices to improve quality
10 and patient safety. Three, improving efficiency through
11 productivity and financial management, and, four,
12 developing integrated information systems.
13 It requires systems of hospitals and
14 physicians working together to achieve those strategies,
15 not independent hospitals; systems of hospitals and
16 physicians working together.
17 It requires resources to which Tenet can
18 provide, expertise to which they provide. They're doing
19 this today across the country, and we need them to bring
20 it here to Connecticut and to Waterbury.
21 So Connecticut hospitals, I believe, are
22 poised to improve health care and to really improve the
23 health of all the communities, and we're interested in
24 improving the health of the Greater Waterbury area here

1 today through this transaction, and we're pleased that
2 the State of Connecticut has partnered with CMS, Centers
3 for Medicare and Medicaid, to create the Connecticut
4 Health Care Innovation Plan.
5 That's a plan that essentially says
6 hospitals need to deal with all those emerging trends.
7 They need to make sure that they have appropriate access
8 to capital. They need to make sure that hospitals can be
9 transparent, that their information systems are talking
10 to each other, that we're attracting the best talent,
11 that we're providing the best clinical quality, that
12 we're providing the best technology available.
13 And, then, now we have a state health
14 plan, which guides us to insure that there's appropriate
15 access to care, because, in the end, that's what it's
16 about, providing appropriate access to care, and we need
17 to be able to look our community in the eye and say we at
18 Saint Mary's can for the foreseeable future provide
19 appropriate access to care, and we can only do that with
20 hospitals like Tenet wrapped around us, with expertise,
21 with experience.
22 So Saint Mary's is prepared for a
23 successful transition to Tenet. We've been blessed over
24 the most recent time to have some strong relative

1 performance, but that's really led by a strong culture,
2 to which Bob spoke to, in terms of our faith-based
3 beliefs, our culture of excellence, family environment,
4 people that truly care about helping others, exceptional
5 clinical quality and safety results, which I will put up
6 against really any hospital anywhere.
7 This hospital here locally is doing some
8 great things, if you haven't read about them, and the
9 people are the reason for that.
10 Exceptional patient experience, a
11 continued effort under making sure that, when a patient
12 comes here, that all of the care is designed around them,
13 not around what's best for us, but around what's best for
14 patients.
15 We still have a lot of work to do with
16 that, and we're going to keep working towards that, and
17 our partners want us to do that.
18 Advanced and tertiary services, that only,
19 you know, community teaching hospitals like Saint Mary's
20 are able to provide for this community, trauma services,
21 neonatal intensive care, open heart surgery, advanced
22 cancer care. All of the surgical services and technology
23 that you could ever want you can get here locally at
24 Saint Mary's.

1 Residency program, we have a commitment to
2 teaching here. We have four residency programs,
3 surgical, medicine, dentistry, med peds through an
4 association with Yale, all of that to train folks as they
5 come out of medical school to do the great things that
6 they should do here locally hopefully for the Waterbury
7 area, but we need to be able to attract talented
8 trainees.
9 We have been able to build some financial
10 strength. That wasn't always the case at Saint Mary's,
11 but we're happy that over the most recent years we've
12 done quite well, but, again, we need to join Tenet for
13 long-term sustainability. That's not going to continue.
14 The fact of the matter is many of the
15 hospitals north of the median on this slide are either
16 part of a system, or they're sole provider in their
17 community.
18 We're an independent hospital that's not a
19 sole provider in this community, so we really need to be
20 part of a larger system, in order to thrive in the
21 future, to continue to build financial strength.
22 We need financial strength, so that we can
23 continue to invest in capital, in talent, in clinical
24 technology.

1 These demands for capital are endless.
2 They are endless. Information technology, we've invested
3 over 10 million dollars in information technology over
4 the last few years.
5 Many hospitals are required to invest in
6 excess of 20 million dollars to provide the
7 infrastructure to transition to population health, this
8 new model of care.
9 That's 20 million dollars that doesn't go
10 towards local health care delivery, so there are endless
11 capital needs, not just about fixing up the facilities,
12 about creating a new delivery system here locally for
13 Waterbury, something to get excited about, a new delivery
14 system that's even better than the one that we have
15 today.
16 So why did Saint Mary's select Tenet?
17 Beyond what Mr. Mazaika provided to you, which is the
18 principals of affiliation, which Tenet has addressed
19 every single one of those, they've also had a commitment
20 to clinical quality and safety that we've investigated in
21 great detail.
22 They've committed to attracting the best
23 talent. They understand that it is people that make
24 hospitals successful.

1 Sustainability in the midst of funding
2 reductions, so there's a funding reduction, hospitals are
3 overweight for the most part. We need to be able to deal
4 with that. We need to say that we can be sustainable,
5 even though Saint Mary's is facing 10 million dollars'
6 reduction in funding next year. We've got to be able to
7 be sustainable moving forward.
8 We've got to be able to address that, and
9 then the next year, and the next year, all the way out to
10 that 2022. We can't just continue to cut. We have to
11 make decisions that are different than those that we may
12 have made in the past, and Tenet can help us be
13 sustainable in the future.
14 They're going to certainly provide
15 expertise and experience that I can tell you very few
16 people in this state have with respect to these new care
17 delivery models and that's exciting. That's exciting to
18 me, and I think, as these new models mature, it will be
19 exciting to you, because it will help you in how your
20 care is delivered in the future.
21 They'll provide access to capital that we
22 don't currently have. We'll get advantages of skill.
23 There's nearly 80 hospitals. With Saint Mary's, 80
24 hospitals. Nearly 200 other outpatient facilities that

1 can help us take advantage of that skill.
2 The benefits of this statewide and
3 national network are going to be tremendous. I can't
4 even explain those benefits, but we'll be able to provide
5 innovation that can never be provided as one hospital
6 independently.
7 We can pilot programs and do things that
8 could never be provided on your own. There's great power
9 and great things that can happen when you've got a lot of
10 hospitals wrapped around, focused on one thing, patient
11 care and doing what's right for patients.
12 And then there's been an unbelievable
13 commitment, as Mayor O'Leary spoke of earlier, to the
14 City of Waterbury, but, beyond that, to the whole State
15 of Connecticut, multiple years that Vanguard, now Tenet,
16 has provided here in the State of Connecticut.
17 Trip Pilgrim is probably a little bit
18 shorter now. Probably got hair a little grayer at this
19 point, but you know what? They're committed. He's
20 committed. He's committed to Connecticut. He's
21 committed to you and to making health care better here.
22 They wouldn't be here, day after day,
23 fighting these fights that they fight, if they didn't
24 care and they didn't want to make a difference, so they

1 are committed to Connecticut. They're committed to Saint
2 Mary's Hospital, and they're committed to the City of
3 Waterbury, and that's why we believe that joining Tenet's
4 national network of hospitals is the best solution for
5 successfully meeting these challenges and for not just
6 surviving, but thriving in the future as we deal with
7 these opportunities ahead of us. Thank you.
8 I will now turn it over to Bob Anthony,
9 who is our general counsel.
10 MR. ROBERT ANTHONY: Good evening. What I
11 plan to do, as Chad mentioned, is to give you an overview
12 of the transaction involving the sale of Saint Mary's
13 assets to Tenet, and I will focus on the key aspects, the
14 key deal terms of our arrangement, and, hopefully, this
15 will not only give you a good understanding of the
16 agreement that we are entering into with Tenet, but,
17 also, our relationship going forward with Tenet and being
18 part of the Tenet hospital systems.
19 As Chad mentioned, I'm the general counsel
20 to the hospital, and I'm one of several advisors that has
21 worked with the Saint Mary's Board of Directors and the
22 Archbishop of Hartford, the management team, and helped
23 negotiating and structuring the arrangement.
24 We've had a number of consultants and

1 experts and advisors that we've brought in and worked
2 with and have had many, many months of negotiations to
3 put this together, and if you think back a few slides,
4 where Joe Connolly was reviewing some of the criteria
5 that the Attorney General at the Office of Health Care
6 Access will review as part of their approval process, one
7 of the requirements is to -- that we exercise due
8 diligence in negotiating the terms and conditions of the
9 agreement, as well as exercising diligence in selecting
10 Tenet and making the decision to transfer our assets, so
11 this will be closely reviewed by these agencies as we go
12 through this process.
13 I'll start by describing the form of the
14 transaction. This is an asset purchase, which is typical
15 in these kinds of transactions, where hospitals purchase
16 other hospitals.
17 Tenet will buy substantially all of the
18 assets of Saint Mary's Hospital, not all of those assets,
19 and I'll discuss those that are sort of outside of this
20 transaction, but it includes, obviously, the hospital and
21 all entities and services that are affiliated with the
22 hospital, including our urgent care centers, our walk-in
23 centers, our surgery centers.
24 It includes our physician organization

1 that employs our internists and specialists and the
2 teaching physicians. It includes all of the equipment,
3 all of the property, the contracts, the leases, so all of
4 the business of the hospital, and it also includes the
5 ownership interest that Saint Mary's has in certain joint
6 venture partnerships, such as the imaging center in
7 Southbury, which is a joint venture partnership with
8 radiologists.
9 In addition to the assets, Tenet will also
10 be assuming certain liabilities, the most important of
11 which is our pension liability, so, as a result of this
12 transaction, the pension will be fully funded, and, as
13 Chad mentioned, our employees' pensions will be protected
14 going forward with a strong financial entity in Tenet.
15 Tenet is also going to assume our capital
16 leases and certain employee benefit type programs,
17 including the paid time off, accrued vacations, those
18 types of liabilities going forward, our supplemental
19 medical benefit plan that we have for retirees, and then,
20 of course, all activities after the closing, that arise
21 after the closing will be Tenet's responsibility.
22 Those assets and liabilities that are not
23 part of the transaction, that Tenet will not be
24 purchasing or assuming, include our insurance company.

1 Saint Mary's has a captive insurance company that
2 provides the professional liability insurance for the
3 hospital, its employees and its employed physicians.
4 As part of this transaction, the
5 professional liability coverage will be provided through
6 Tenet's insurance programs.
7 The Saint Mary's Hospital Foundation also
8 will continue to remain a taxable, charitable foundation.
9 It will not be part of the transaction. The Foundation
10 holds gifts in certain donor restricted funds. These are
11 monies that have been donated for specific purposes, and
12 the intent of the donors that have made those gifts will
13 continue to be carried out.
14 The Foundation will also receive the
15 residual proceeds from the sale as part of this
16 transaction, and those funds will be used to support
17 local health care needs and to further promote the
18 Foundation's mission.
19 Certain items will remain with Saint
20 Mary's. They'll keep its cash and investments, and
21 they'll actually be used to pay off some of the hospital
22 debt, such as tax-exempt bonds and other long-term debt.
23 It includes a number of other items,
24 again, that will stay with the hospital. An example is

1 these Medicare cost settlement reports. Saint Mary's is
2 required to file a cost report with Medicare every year.
3 Medicare uses the information in those filings to
4 determine if the hospital has been underpaid or overpaid,
5 and those settlements often times take many years to
6 resolve, so those types of things will stay with the
7 hospital.
8 There's other liabilities, those existing
9 prior to the closing, again, that Tenet is not assuming,
10 and these are things like environmental liabilities, and
11 we've had numerous environmental assessments done here at
12 the hospital over the past few years. All have come back
13 very favorable.
14 We've had to make some -- we've had to
15 clean up some small areas, but, for the most part, we're
16 not concerned about any significant environmental
17 liabilities.
18 There's also asbestos abatement expenses
19 that potentially could be incurred that will remain a
20 responsibility of Saint Mary's.
21 There's the regulatory issues, the
22 Medicare, potential Medicare overpayment issues or
23 billing issues. Those will also remain an obligation of
24 Saint Mary's Hospital, and we've actually negotiated time

1 limits on those, so those obligations don't extend out
2 forever. Most are limited to an 18-month period
3 following the closing, and we have caps, financial caps
4 on our liability for those, as well.
5 We've also agreed to set up what's
6 referred to as an indemnity fund, or a reserve fund,
7 which will hold back some of the cash from the proceeds
8 to cover any potential liabilities or obligations that we
9 may need to satisfy after the closing.
10 The purchase price is 150 million dollars
11 in cash, and that number gets adjusted at the closing,
12 based on a number of factors, one of which is what's
13 known as networking capital, which is essentially looking
14 at the current assets and current liabilities of the
15 hospital today, and then adjusting for the current assets
16 and current liabilities at the closing, which could be,
17 obviously, several months from today, so the purchase
18 price could be adjusted upwards or downwards, based on
19 the working capital.
20 The purchase price is also going to be
21 reduced by the pension liability being assumed by Tenet,
22 the capital leases that I had referred to, and some of
23 the other, well, all of the other liabilities that Tenet
24 is assuming, based on some contracts and employee-related

1 type activities.

2 In addition to the purchase price, Tenet
3 will also commit to spend no less than 85 million dollars
4 over seven years, which will allow Saint Mary's to invest
5 in its facility's renovations, upgrading of equipment,
6 expanding clinical departments and services, and other
7 activities to enhance the services that we provide in the
8 community.

9 Governance, there will be a local Advisory
10 Board in Waterbury, here at Saint Mary's, to oversee the
11 hospital and provide meaningful input and to decisions
12 affecting the hospital.

13 The Board will be involved in developing
14 and providing recommendations regarding the strategic
15 plan, the hospital's strategic plan, its annual operating
16 and capital budgets, decisions on how to spend the 85
17 million dollars that will be committed over seven years.

18 The local Advisory Board will also
19 continue to be involved with medical staff credentialing,
20 overseeing quality improvement initiatives and quality
21 assurance programs here at Saint Mary's, accreditation
22 standards, so they'll have meaningful involvement going
23 forward.

24 And the members of that Advisory Committee

1 will include the Archbishop of Hartford or his designee.
2 It will include the CEO of Saint Mary's Hospital and
3 local community representatives.
4 Initially, those will be appointed by
5 Saint Mary's, and it will include at least two
6 physicians, who currently serve on the Saint Mary's
7 Hospital medical staff.
8 The Advisory Board will have
9 subcommittees. One standing subcommittee will be what's
10 known as the Mission Integration Committee, and that
11 committee will be responsible for oversight of
12 integration of mission and core values into the hospital
13 activities, and the local Advisory Board will also have
14 certain reserve powers during the first five years.
15 If there is a proposal to sell or close
16 the hospital or other disposition of the hospital within
17 the first five years, that local Advisory Board would
18 have to first approve that type of activity, and that
19 type of activity also would have to go through a
20 Certificate of Need process and be approved by the State.
21 Tenet will continue to operate the
22 hospital in accordance with community benefit standards,
23 and those are standards that are established by the
24 Internal Revenue Service that are required of all tax-

1 exempt charitable hospitals.

2 In addition to those standards, which
3 include maintaining charity care policies, accepting
4 Medicare and Medicaid patients, all emergency patients
5 with regard to their ability to pay, promoting public
6 health and wellness programs and health education in the
7 community, doing community needs assessments, Tenet will
8 also maintain Saint Mary's current charity care and
9 indigent care policies, as they currently exist, and,
10 also, the hospital's community outreach programs.

11 As you heard before, Saint Mary's will
12 stay Catholic. It will retain its name. It will
13 continue to honor its Catholic heritage and adhere to the
14 ethical and religious directives.

15 There will be an Ethics Committee, which
16 will be responsible for the day-to-day monitoring of
17 compliance with the ethical and religious directives, as
18 well as other ethics-related matters.

19 The Chairman of that committee will be
20 appointed by the Archbishop of Hartford, and the
21 committee will have the responsibility of reporting ERD,
22 Ethical and Religious Directives, compliance to the
23 Archbishop.

24 There will continue to be a Pastoral Care

1 Department, and the director of the Pastoral Care
2 Department will be appointed by the Archbishop, and that
3 member the Director will serve on the Senior Management
4 Team of the hospital.
5 The medical staff bylaws, the employee
6 codes of conduct and all documents related to the
7 hospital will require adherence to the ethical and
8 religious directives, as they do now, and there will
9 continue to be a chapel, all the appropriate signage and
10 religious artifacts, and other symbols of Catholic
11 identity will continue here at the hospital.
12 The Archbishop of Hartford has the ability
13 at any time in his sole discretion to withdraw
14 recognition of the hospital as a Catholic identity, if he
15 so chooses, and to require that the right to the name,
16 the religious artifacts and other symbols of Catholic
17 identity be withdrawn, if he deems appropriate, so he
18 reserves that ongoing right.
19 Employees will, all active employees, will
20 be offered employment at their current salaries and with
21 comparable benefit packages currently provided by Saint
22 Mary's.
23 The Foundation will have certain reserve
24 rights, the right of first opportunity to buy back the

1 hospital within the first five years in the event
2 there's, again, a proposal to sell the hospital. In
3 addition, if the hospital is sold and it is sold for more
4 than the purchase price that Tenet is paying for it, the
5 Foundation will get 20 percent of the excess proceeds
6 from that sale.
7 Conditions to closing, there a number of
8 approvals. Obviously, the Attorney General's Office and
9 the Office of Health Care Access will do a very detailed
10 comprehensive review.
11 They will have a minimum of two hearings,
12 we expect. They will hire their own experts to help
13 assist them with their evaluation.
14 We are required to have an independent
15 firm evaluate and confirm that the purchase price is fair
16 and reflects fair market value, and we've done that, and
17 we've gotten that confirmation.
18 There will be an anti-trust analysis as
19 part of the reviews. This will be, the transaction will
20 ultimately be approved by Rome as part of the canonical
21 process. If there's any material changes, and they would
22 have to be significant, that occur between now and the
23 closing, then the agreement that we have could be
24 terminated, and we certainly don't expect that, but it's

1 a very standard provision in contracts and transactions
2 of this type.
3 So once all of the reviews are completed,
4 and there could be conditions placed upon the approvals,
5 but, once that's done, there will be a final closing,
6 and, after the closing, then the deal with Tenet goes
7 into effect.
8 So, at this time, I would like to invite
9 Dr. Gumbardo, who is Chief of the medical staff and one
10 of the physician leaders at Saint Mary's, to present
11 next.
12 DR. ROBERT GUMBARDO: Thank you, Bob.
13 Good evening. As health care continues to evolve, being
14 part of a larger regional network will be essential. The
15 Tenet transaction is a strategic decision that positions
16 Saint Mary's for the future.
17 This relationship will be good for the
18 hospital, it will be good for the hospital's employees,
19 it will be very good for the medical staff, but, most
20 importantly and what should be our first and foremost
21 thought, is it's what's best for our patients.
22 It will insure quality care and greater
23 access to care to the Waterbury community for this and
24 future generations.

1 There are over 480 physicians and medical
2 care providers on the staff here at Saint Mary's. The
3 medical staff strongly supports Saint Mary's Hospital
4 joining the Tenet network. Thank you very much.
5 SPEAKER CONNOLLY: Okay. For those of
6 you, who are keeping track, if we were an airline, we'd
7 call this an on-time arrival. (Laughter) We promised 60
8 minutes, and it is 58 minutes in, so we're good.
9 I now would like to open it up. We've got
10 the people, who have signed in. I would just like to
11 take a quick moment. I'm going to do two things before
12 we get going.
13 First, I'll introduce -- what we're going
14 to do is we're going to turn the slides off, and we'll
15 have a panel come up, and the members of the panel will
16 be most of the gentlemen who you just heard from, Chad
17 Wable, Robert Mazaika, Bob Anthony, our attorney, and Dr.
18 Gumbardo.
19 They'll be joined by Trip Pilgrim from
20 Tenet Healthcare, as well as Erik Wexler. They'll form
21 our panel in just a moment.
22 I'd like to take a minute to review just
23 some of the guidelines that we kicked off the meeting
24 with. The first is, if you'd like to speak, we'd love to

1 hear from you. You need to sign in in the back, so, if
2 you haven't already signed in, please do that, and we
3 will take people in the order that they've been signed
4 in.
5 When I call your name, I'll call the names
6 from this podium, and I'd ask that everybody please use
7 that microphone on that side of the room.
8 Again, a reminder that everything is being
9 recorded and will be submitted to the State as part of
10 our overall testimony.
11 Before you begin your comments, please
12 state your name and your city of residence, and, in the
13 interest of time, please try and limit your comments to
14 approximately five minutes. We'd appreciate that.
15 Again, all comments should be directed
16 towards this transaction and the proposal that you've
17 heard about earlier this evening, and if for any reason
18 somebody has decided that you'd no longer like to testify
19 or speak, when I call your name, just say no comment, and
20 that will be that. No problem.
21 Last, but not least, if anybody has
22 written testimony that they'd like to submit, you can
23 submit that at the back of the room, and we'll make sure
24 that that gets integrated into part of the overall

1 package.

2 So, with that, I'm going to ask our panel
3 to come to the front, and I would also like to invite
4 Monsignor James Coleman to come. Monsignor Coleman is
5 our first speaker for this evening.

6 MONSIGNOR JAMES COLEMAN: Good evening.
7 I'm Monsignor Jim Coleman. I live in Waterbury. I'm at
8 St. Peter and Paul Parish in the East End of Waterbury.
9 I was born here at this hospital 78 years ago, so I'd
10 like to comment just a brief comment about how much I
11 admire Saint Mary's and how happy I am with the position
12 we find ourselves in tonight.

13 Psychiatrist, psychologist, Erik Erikson
14 said a long time ago the beginnings of everything begins
15 with trust. When we're born, the first thing we have is
16 acquiring a sense of basic trust while overcoming basic
17 mistrust, and I guess what this night is all about is
18 bringing ourselves to acquire that sense of trust.

19 The presenters so far tonight have given
20 us an opportunity to hear of a very intriguing and
21 hopefully hopeful process that will bring Saint Mary's to
22 deal with the difficulties of the future, the challenges
23 of the future.

24 I find myself totally in accord with the

1 proposal that's been given. I serve as Episcopal vicar
2 in this area. I represent the Archbishop when he's not
3 able to attend, and I will certainly tell him tonight of
4 the wonderful meeting we've had here, and I hope that
5 we'll always have trust in Saint Mary's.
6 From the very first day that I began here
7 at Saint Mary's to work as a part of the Board,
8 Archbishop Cronin said the important thing is the
9 employees and the people.
10 Archbishop Mansell came and said what we
11 have to do is maintain our ability to be trusted, and he
12 worked toward establishing the -- overcoming the
13 difficulty with the pension liability. Archbishop
14 Mansell even went to Rome to sit down to discuss what was
15 going on here at Saint Mary's.
16 And now we have Archbishop Blair, and we
17 have a community of people being presented with an
18 opportunity to let Saint Mary's prosper for the years
19 ahead. Thank you very much. (Applause)
20 SPEAKER CONNOLLY: Next, I'd like to
21 invite State Representative Selim Noujaim.
22 MR. SELIM NOUJAIM: Thank you, Mr.
23 Connolly. Good evening, everyone. I'm honored to be
24 here this evening to support this transaction with Tenet

1 Health Network.
2 Basically, I have been associated with
3 this hospital, Saint Mary's, from the first day I
4 immigrated to this country from Lebanon back in 1971.
5 I met my wife. My wife was born here at
6 Saint Mary's, my three children were born here at Saint
7 Mary's, and through the joys that we have over the past
8 several years, we also had some very difficult situations
9 that happened at Saint Mary's, most recently the passing
10 of my mom a few months ago.
11 One thing remains very constant is the
12 care of the staff. The staff at Saint Mary's some of
13 them have retired. Some of them are still active here at
14 our hospital have become friends. We don't refer to them
15 by numbers. We refer to them by name.
16 From the top, all the way down, they have
17 been cordial, they have been dedicated, they have been
18 true professionals.
19 One of the issues that I support in this
20 transaction is the fact that the funding will be funded,
21 the pension plans will be funded. That is very
22 important.
23 I would like our retirees, our current
24 members to be able to go to bed at night, knowing that

1 their pension plan is fully funded, knowing that they
2 will be secured when they retire.
3 The other issue that is very important to
4 me and I am so happy that every member of the panel, who
5 spoke about it, is the aspect of religion.
6 As a devout Catholic, myself, I have been
7 accustomed to see Saint Mary's Hospital being a Catholic
8 hospital. I am very pleased that it's going to remain a
9 Catholic hospital.
10 One of the issues that is very important,
11 which probably has not been addressed yet, is the fact
12 that, once this hospital becomes a for-profit hospital,
13 it will give some revenues, tax revenues, personal
14 property taxes to the City of Waterbury. That is very
15 important.
16 It will reduce the liabilities of the
17 residents, the homeowners, which will help to keep our
18 tax rate down, and, hopefully, it will reduce our tax
19 rate here in the City of Waterbury.
20 Additionally, one thing that is very
21 important, also, what I will call buy-in power. Being a
22 businessman, myself, I know that, if you buy one Band
23 Aid, it's a price, but if you buy 10 Band Aids, you get a
24 better price.

1 Being associated with a network of
2 hospitals then will be able to help buy-in power, which
3 will reduce the cost, which, in fact, will help reduce
4 the community.
5 And, also, from a legislator's
6 perspective, I know and I believe that once we have
7 better negotiation power with insurance companies, to be
8 able to have bigger, better revenues, higher revenues,
9 and, also, to negotiate with the State and with the
10 federal government for better rates.
11 I know that President Chad Wable spoke
12 about the cuts that have taken place in Medicare and
13 Medicaid. That is very important to all of us.
14 And one thing that is very important, too,
15 is the fact that 85 million dollars is being committed by
16 Tenet over the next seven years. That would be very
17 important how many jobs that will bring to the City of
18 Waterbury, how many people we hire, how much money we'll
19 be able to put into our community and into the rest of
20 our community.
21 All these are factors that are very
22 important to us. I remember, about 20 years ago, a dear
23 friend of mine, who at the time was a President of Saint
24 Mary's Hospital, made this kind of recommendation, and he

1 was scolded by the Archbishop back then. The Archbishop
2 would not agree to those type of transactions.
3 Times have changed. Economies have
4 changed. Things have changed, and now we should move on
5 and move on to better things for our communities.
6 And I think I forgot to follow your lead
7 or your question by stating my city of residence. I do
8 reside very proudly in the City of Waterbury. Thank you
9 very much, and God bless you, all. (Applause)
10 SPEAKER CONNOLLY: Our next speaker is
11 Lynn Ward, the CEO of the Greater Waterbury Regional
12 Chamber of Commerce.
13 MS. LYNN WARD: Good evening. I'm Lynn
14 Ward, President and CEO of the Waterbury Regional
15 Chamber. I reside in Wolcott.
16 Our Chamber serves 13 towns in the Greater
17 Waterbury Region, and we represent the collective
18 interest of nearly 1,000 businesses in matters of public
19 policy and economic development.
20 The Chamber strongly supports the proposed
21 acquisition of Saint Mary's Hospital property by Tenet
22 Healthcare Corporation.
23 We are proud to partner on numerous
24 economic development efforts in our region, and, in that

1 regard, the proposed acquisition represents a very
2 positive initiative. Today's hospitals operate in a
3 continually-changing, highly-competitive environment,
4 recognizing this. The proposal now before us would
5 provide Saint Mary's the resources needed to continue its
6 role as a leading local company that serves as one of
7 Waterbury's largest employers.
8 The Chamber's public policy programming
9 also continually advocates for measures that improve
10 local quality of life. We're aware that a strong health
11 care system plays a critical role in where companies
12 choose to do business, that Tenet Healthcare provider,
13 with an excellent track record of operating state-of-the-
14 art facilities would invest in Saint Mary's Hospital is
15 welcome news to the business community.
16 This investment would provide resources
17 that insure the facility can continue to deliver the high
18 level of health care needed in Greater Waterbury.
19 In addition, the Chamber's municipal
20 agenda supports initiatives and programs that expand the
21 commercial segment of Waterbury's Grand List.
22 Growth and the tax base will have a major
23 impact in making the city more attractive to companies
24 looking to expand or relocate. Because this proposal

1 will provide a significant increase in local tax revenue,
2 it both directly fosters economic development as a city's
3 ability to attract future economic development.
4 Again, on behalf of our Board of Directors
5 and more than 1,000 members, we strongly support the
6 proposed acquisition of Saint Mary's Hospital and health
7 system by Tenet Healthcare Corporation. Thank you.
8 SPEAKER CONNOLLY: Thank you, Lynn. Next,
9 Dr. Jerry Sugar.
10 DR. JERRY SUGAR: I'm Jerry Sugar. I live
11 in Waterbury, Connecticut. I've been in private practice
12 in Waterbury for 36 years.
13 During that time, I have had the pleasure
14 to serve as the Chief of the medical staff at Saint
15 Mary's Hospital. It was just the last two years.
16 Most recently, I've served as a physician
17 representative to the Board Task Force that has worked on
18 this proposed transaction between Saint Mary's and Tenet
19 Healthcare Corporation.
20 The Task Force has been diligent in its
21 work for more than four years. We have spent countless
22 hours debating the pros and cons of various scenarios and
23 options for Saint Mary's. We have performed extensive
24 due diligence. We have traveled throughout the country

1 conducting site visits.
2 Throughout all of these deliberations, we
3 have been guided by very specific principles and an
4 abiding commitment to do what is right not only for Saint
5 Mary's, but for the entire Greater Waterbury community.
6 We have considered the entire health care
7 delivery system, including the impact on our local
8 medical staff. The benefits of this proposal will help
9 to strengthen and enhance the health care in our
10 community by making strategic investments and by helping
11 to recruit the most talented physicians.
12 I believe that, as a faith-based
13 organization, Saint Mary's fulfills and important role in
14 the fabric of our community. I am comforted to know that
15 this important role will be continued under the terms of
16 the proposed transaction with Tenet.
17 It is for this reason and many others that
18 I support this proposal and urge others to do the same.
19 SPEAKER CONNOLLY: Next, Mr. Nick Coscia.
20 MR. NICK COSCIA: Good evening, gentlemen.
21 How are you? I spent 76 years in this City. I'm very
22 knowledgeable about both hospitals.
23 My family and myself have always been well
24 taken care of in this community. I just had open heart

1 surgery three years ago, and thanks to Saint Mary's
2 Hospital and Waterbury Hospital working together, I'm
3 standing here today talking to you.
4 There's a lot of things of uncertainties,
5 not only with the people here, but the senior citizens,
6 too. I'm an advocate for the senior citizens, but I
7 speak for myself here this evening.
8 You have to see it, and you have to prove
9 it. Seventy-six years, I've seen both Waterbury and
10 Saint Mary's Hospital working together through all types
11 of emergencies.
12 There's over 100,000 people in this City.
13 I won't be around another 76 years to see what you people
14 can do, but I pray to God you give Waterbury the same
15 services that we got.
16 Now some of the things, some of the
17 questions I'd like to say. Medicare Part A and Part B,
18 I've been all up down the country now, from Florida to
19 North Carolina to Connecticut to Canada. I've been doing
20 the research on Medicare Part A and Part B.
21 Will you guarantee the people of the City
22 of Waterbury Medicare Part A and Part B? Also, I have a
23 private insurance plan. My last operation was $125,000
24 for my heart. It didn't cost me that much, because I had

1 Medicare Part A and B, but we don't want to be going --
2 we want to insure the people that they're going to be
3 able to get this.
4 You talked about insurances. Well you
5 have insure, make sure that the people that are here will
6 get this type of service. That's some of the
7 uncertainties.
8 You talk about the ethnic backgrounds. I
9 have four different ethnic backgrounds and four different
10 religions, so when you say Saint Mary's is a Catholic
11 hospital, can you identify that you're going to take care
12 of all ethnic backgrounds and all religions?
13 You were going kind of fast on the Board,
14 so I jotted what I could.
15 Now both hospitals were coordinating
16 together ever since I was born. I was born in Waterbury
17 Hospital, and Saint Mary's Hospital did treatments for me
18 and my family and my mother and father and everything
19 else.
20 We've had excellent care. Now how can you
21 go beyond excellence when we've had excellence? It's
22 going to be pretty hard to prove, and I hope you do a
23 good job.
24 I won't be around 76 more years, unless

1 you got some pill that will keep me around. That will
2 make me 152 years old.
3 Let's see. Okay. The heart facility, I
4 was an advocate for the heart facility in this hospital.
5 Will you guarantee that that heart facility is going to
6 stay here, so the patients don't have to go down to St.
7 Raphael's or somewhere else? I never knew that I was
8 going to be the heart patient.
9 The hospital's existing staff, will some
10 of the same staff be on here while the transition period
11 happens, and when will the transition period begin?
12 Maybe you can answer some of these questions, because, to
13 make this transition, with all the things that are going
14 on and all these weather conditions that are going on,
15 are you prepared during these transition periods for
16 emergency conditions?
17 The first thing when I was on the
18 operating table I asked if the generator was working in
19 the hospital. It's crazy, but it's one of those -- you
20 do have a generator. I know that, but the point is I'm
21 thinking about things that the doctors and you lawyers
22 don't think about, because, when you're on that table and
23 those pumps are working, you only got one chance.
24 And the other thing I've got to say is my

1 son had Guillain-Barre, and I had open heart surgery, and
2 we had a closed-loop system, so that's because of our
3 religious beliefs and everything else. Both Dr. Anthony
4 and both Dr. Price(phonetic) accepted our feeling.
5 Let's see. I guess that's it. Thank you.
6 SPEAKER CONNOLLY: Thank you, Nick. Chad,
7 who is going to?
8 MR. TRIP PILGRIM: Trip Pilgrim with Tenet
9 Healthcare. All our hospitals participate in Medicare
10 Part A/Part B, and I can't imagine operating in the
11 markets we operate would not continue to take Medicare
12 Part A and Part B, so, yes, we will be doing that.
13 MR. WABLE: Nick, I'll try to keep up with
14 you and rattle down through your questions here. Do you
15 have another question? You all set?
16 MR. COSCIA: Oh, yeah.
17 MR. WABLE: Okay. Let me try to answer
18 the rest of your questions. First of all, thanks for
19 asking these questions.
20 You asked a question about our taking care
21 of you, regardless of your faith, or creed, or what your
22 beliefs are, and that's absolutely true.
23 We're a hospital. We take care of
24 everyone, regardless of their ability to pay, regardless

1 of their belief systems. We have a certain belief system
2 here as a faith-based hospital, as a Catholic hospital
3 that we follow, that we've followed for the 110 years
4 we've been here in Waterbury. We're going to take care
5 of everyone in this community that comes here to Saint
6 Mary's.
7 The next question is how do we guarantee
8 that health care will be better? You know we have
9 provided great health care, and thanks for commenting on
10 that, and I'm glad that you're here and you've been a
11 benefit of this health care delivery system.
12 I truly believe that the partnership that
13 we have with Tenet, all the resources that we're going to
14 wrap around developing a better health care delivery
15 system is going to provide better health care.
16 This is all about improving quality,
17 improving service, and providing better access to care in
18 the future.
19 Now, again, the proof is in the pudding,
20 right? So we're going to have to prove that out, and I
21 think we're all committed to do that.
22 Next thing you asked is the Heart Center.
23 The Heart Center has been a very good thing for this
24 community. Bringing a lot of services back here locally

1 to the Waterbury area has done a lot of good for a lot of
2 people.
3 I read letters all of the time of miracles
4 that happen with respect to the Heart Center. We're
5 going to continue to collaborate like we always have
6 within the Heart Center with Waterbury Hospital, and
7 that's going to be an important component of the services
8 that we provide here locally in this community.
9 Transition period, I can't speak a lot to
10 the transition period, but I know we're going to put the
11 patients first with respect to the transition period here
12 at Saint Mary's, and we're going to work hand-in-hand
13 with Tenet and their folks to make sure that whatever the
14 transition is, whatever the time period is, that we make
15 sure that we put patients first during that transition
16 period, and that's the only guarantee I can give you at
17 this point.
18 MR. PILGRIM: I was just going to say,
19 sir, that, you know, transition period, if done right,
20 shouldn't change anything for you, the community.
21 A lot of the transitions that occur is a
22 lot of stuff you'd never see. It's the revenue cycle,
23 it's the IT systems, it's the H.R. systems, it's the
24 reimbursement, legal, etcetera.

1 And then you're asking a question about
2 staff, and I want to be clear that the intention isn't to
3 transition any staff out. I mean this is a high-quality
4 hospital, with an engaged workforce that does great work
5 every day, and, so, our intention here, as it is in other
6 markets where we've gone in, is to, you know, retain,
7 keep the staff. They live in the community.
8 Health care is a local business, and we
9 want to make sure that we can continue that.
10 SPEAKER CONNOLLY: Next, Eleanor Regan.
11 MS. ELEANOR REGAN: Good evening,
12 gentlemen. My name is Eleanor Regan, and I'm a resident
13 of the City of Waterbury and long-time user of Saint
14 Mary's Hospital. Thank you very much.
15 Before I came here, in preparation for
16 this meeting, I did visit your website, and, as I visited
17 the website, certain things popped out at me, and I'm
18 going to pose two of them to you tonight, one of which I
19 have to say, Mr. Anthony, you answered quite lovely in
20 your presentation. I enjoyed your presentation very
21 much. Thank you.
22 One of them, though, had to do with the
23 statement on the website, that Tenet operates with
24 guidance from the local Archdiocese, and, as I recall

1 your presentation, you did answer that in quite a bit of
2 detail, and I was glad to hear it.
3 I was just kind of interested in knowing
4 if you could explain the power of the Archbishop on your
5 Board of Directors. Does he have absolute power of veto
6 anymore, or is it a one-man, one-vote relationship? I
7 don't know. I'm just kind of curious that was brought
8 up.
9 MR. MAZAIKA: I'm Bob Mazaika. I'm
10 Chairman of the Board. Typically, the Archbishop has
11 been Chairman of the Board of any hospital, both St.
12 Francis and Saint Mary's, but Archbishop Mansell decided
13 before he retired to appoint a lay Chair, and, so, I
14 happen to be the first lay Chairman of Saint Mary's
15 Hospital, and there's a lay Chairman of St. Francis,
16 also.
17 The Archbishop has, and I may throw this
18 back at Bob Anthony, but the Archbishop has certain
19 reserve powers. He has the power to take me out of my
20 job anytime he wants, but he also has a right, as Bob
21 explained, that if we do not follow the ethical and
22 religious directives, that he can say this is no longer a
23 Catholic hospital.
24 He has to approve the sale of the entity,

1 in which he has done, but he also has to get Rome's
2 approval, so it goes -- it really goes beyond the
3 Archbishop. And within this structure that we've put
4 together with Tenet, he will retain certain reserve
5 powers, and he has certain rights to appoint, as Bob was
6 saying, several people to key positions in the hospital
7 to insure that the hospital remains in its Catholic
8 identity and continues to operate under the religious and
9 ethical directive. Does that help you at all?
10 MS. REGAN: Yes, it does. I was
11 interested in your statement about he could take Saint
12 Mary's name off the hospital. I wonder what would happen
13 to the hospital, then, if that did happen, not that it's
14 going to happen, but, if it did, what would happen to the
15 hospital?
16 MR. MAZAIKA: It would become a secular
17 hospital.
18 MS. REGAN: I see. And that's it?
19 MR. MAZAIKA: And that's it.
20 MS. REGAN: Okay. We wouldn't close our
21 doors?
22 MR. MAZAIKA: No, no. No, no. No, no,
23 no. It just would not be recognized as a Catholic
24 institution.

1 MS. REGAN: Um-hum. Um-hum. Okay. The
2 other thing that popped out as I was reading that
3 website, there was something alluded to, and I just
4 jotted it down. There were duplicate services located at
5 one campus or another, and I was wondering what those
6 duplicate services might be, if you have any idea what
7 they are at this point in time? Would they be human
8 resources, or I don't know?
9 MR. WABLE: This is Chad Wable.
10 MS. REGAN: Yes.
11 MR. WABLE: Sorry. Chad Wable. There's a
12 whole host of what you would consider to be duplicative
13 services, meaning services that we provide on this campus
14 that are also provided over at Waterbury Hospital, and
15 that's everything, from all the back office type
16 services.
17 MS. REGAN: Human Resources.
18 MR. WABLE: Those would be services that
19 are duplicative, as well as all the clinical services
20 that are duplicative to one another.
21 MS. REGAN: That's what I was wondering
22 about, the clinical services that are maybe not back
23 door. I'm thinking especially radiology, you know,
24 especially with the MRI machine that's basically out of

1 date the minute you install it. I'm given to understand
2 that. I'm not sure how true it is, but would those
3 things be shared by both hospitals, then, Mr. Wable?
4 MR. WABLE: This is Chad Wable. We're not
5 planning to eliminate any services that are provided at
6 Saint Mary's in our particular transaction here, so all
7 the services that are provided here are going to remain
8 at Saint Mary's.
9 MS. REGAN: Even at a great deal of
10 expense, then? I don't know. I'm just asking that
11 question.
12 MR. WABLE: I think --
13 MS. REGAN: That makes sense to me.
14 MR. WABLE: Under the arrangement of a
15 common owner with Tenet with two campuses at Saint Mary's
16 Hospital and with Waterbury Hospital, there's going to be
17 opportunity for us to work with the community, the
18 medical staff, and everyone else to develop a better
19 health care delivery system, and, so, maybe there are
20 instances where some of the services don't necessarily
21 need to be duplicative in the future, and we're going to
22 have to get together and really plan out what that might
23 look like, but we need your help, we need the help of the
24 medical staff and a lot of others.

1 MS. REGAN: Okay, so, that hasn't been
2 decided yet, about what services would be consolidated?
3 MR. WABLE: That has not been decided.
4 Trip, do you want to make a comment around that? Erik?
5 MR. ERIK WEXLER: Good evening. My name
6 Erik Wexler, and I'm the CEO for the Northeast Region at
7 Tenet, so the hospitals in Connecticut that we're
8 affiliating with would be part of my region.
9 I just want to say it is almost surreal
10 for me to be here tonight in front of all of you, because
11 I worked here for many, many years in health care, and I
12 am absolutely delighted to be sitting here in this
13 auditorium tonight.
14 Health care for me in my career started in
15 Waterbury, so I am very, very passionate deep in my heart
16 about what we do here in Waterbury to insure that the
17 care that we provide to the community continues to be
18 absolutely superb. I still have a lot of friends that
19 live here.
20 Let me just -- there are two things I
21 wanted to address, but, first, I wanted to speak to this
22 issue of what services could be consolidated, and I think
23 Chad said it well. It's hard to know exactly at this
24 point how we could work better together.

1 I think part of the problem that we've all
2 faced when I was here in Waterbury is that we were always
3 working against each other, the two hospitals, and the
4 opportunity for us to try to find a way to do things in a
5 partner-like way, as we have done in cancer care, as we
6 have done in cardiology, I think they're shining examples
7 of the types of things we can do more of.
8 The key, though, I think for us is to try
9 to keep care in our community. Our problem has been that
10 many people in our community, and I would suspect not the
11 people sitting in this room tonight, who are here
12 passionately concerned about where we are headed, but
13 many people in our community may have gone to other
14 places to get care.
15 They may have gone west. They may have
16 gone east. And, so, what we want to do is find a way to
17 keep more people here, so that we don't have to eliminate
18 services, but to grow them.
19 The other thing I wanted to go back to,
20 something you mentioned about the Saint Mary's name. You
21 asked a very good question. If that name were to go
22 away, what would happen? Mr. Mazaika properly said, then
23 we'd become a secular hospital. That is definitely not
24 what we want to have happen.

1 I was the CEO of St. Vincent Hospital in
2 Worcester, only right up the highway, part of Tenet, and
3 we protected our religious mission fiercely.
4 We insured and I, as the CEO, every day
5 insured that the ethical and religious directives of the
6 church would be respected and that we would remain a
7 Catholic hospital, and that is exactly what we would want
8 to happen here at Saint Mary's. Never would we want the
9 Catholic mission to disappear.
10 SPEAKER CONNOLLY: All set?
11 MS. REGAN: Thank you very much,
12 gentlemen. I appreciate it. I enjoyed every one of your
13 presentations, by the way. Thank you.
14 SPEAKER CONNOLLY: Thank you. Our next
15 speaker is Bill O'Brien.
16 MR. BILL O'BRIEN: Good evening. I'm Bill
17 O'Brien. I'm President of Connecticut Right to Life, and
18 we're based right here in Waterbury.
19 We have not taken a position on this
20 merger, the buyout as yet, but we are very concerned
21 about it, very concerned about the direction of health
22 care in this country. Number one, of course, with
23 abortion. We fought assisted suicide twice in the last
24 two years in the legislature here and many other things

1 that are going on.
2 Waterbury has a particular culture, a very
3 Catholic culture. I think more seminarians came out of
4 Waterbury than any other city in the country for a long
5 period of time.
6 Father McGivney may be the first Catholic
7 Saint as a priest from the United States, born right
8 here. Coming in, I saw the Holy Land Cross, so it's a
9 very, very Catholic culture here.
10 Everyone has sort of been positive. I've
11 got a few negatives. I've looked up Tenet, and, you
12 know, they've got a lot of capital. That's a good thing.
13 Experience running hospitals for profit. Don't
14 necessarily have a problem with that.
15 There's been a few things in the newspaper
16 and looking it up. Between 2002 and 2007, Tenet was
17 charged with various ethical violations, including, you
18 know, fraud, over billing for Medicare or Medicaid, and
19 kickbacks to doctors and paid over a billion dollars in
20 restitution for those or fines.
21 I also looked up on Tenet's the ethicists
22 for Tenet, and, again, we're a very Catholic culture
23 here, very evangelical, Orthodox Jewish population and
24 more maybe coming in in larger numbers.

1 On the other hand, Tenet's Chief Ethicist
2 is, at least two years ago, I guess, was co-Chairman of
3 the Board of Directors of the Human Rights Council, which
4 is the biggest gay rights organization in the country,
5 pushing for gay marriage and all that.
6 So, in some sense, I get the feeling like,
7 you know, obviously, planned parenthood they do hundreds
8 of thousands of abortions. Waterbury Hospital did seven
9 the last I heard. There's no comparison, except for
10 their policy is the same on abortion.
11 And I get the feeling like what's the
12 difference, as to if Saint Mary's was bought out by
13 Planned Parenthood? You're going to be owned by the same
14 company that owns Waterbury Hospital that does abortions,
15 the same company that owns DMC Hutzel Women's Health
16 Hospital in Detroit.
17 They do IVF, donor eggs, sperm injection,
18 surrogate parenting, frozen embryos, long-term birth
19 control, tubal ligations. That's just one I found.
20 I called up St. Vincent's in Worcester
21 last week, and just as a little test I asked, you know,
22 do you have an IVF program, and, within 30 seconds, they
23 failed the test. They referred me to Reliance. I'm not
24 sure who they are, but, apparently, they do IVF, and, as

1 far as I know, a referral for IVF would be a violation of
2 the ERDs.
3 One question for you. In light of the
4 Hobby Lobby decision, how will that effect, you know, if
5 -- I was pleased with some things I heard tonight about
6 the degree of control of the local Board and the
7 Archbishop and so on.
8 At the same time, you know, we're not
9 owned by a Catholic health care system, like Ascension or
10 something, but a secular profit-making group. In light
11 of the Hobby Lobby case, which said that a religious
12 organization did not have to pay or fund a health care
13 insurance for their employees, what would be the case
14 with Saint Mary's Hospital?
15 Is it still Catholic and falling under
16 that exemption or under the Supreme Court ruling or not?
17 I'm not sure what Saint Mary's health care includes now,
18 if it includes abortion or contraception. Hopefully not,
19 but would it under the new laws under that Supreme Court
20 decision?
21 I'm just curious, if Ascension was one of
22 the very finalists, maybe the runner up, how come they
23 weren't chosen?
24 And how would this arrangement, with

1 abortions being done across town, how would that be
2 different from two years ago, when there were maybe five
3 or six different proposals on how to do abortions, but
4 not on the Saint Mary's campus, but to be done some other
5 way? How is that going to be different than being owned
6 by a company that's still doing them?
7 I grew up in Bridgeport. I was born at
8 St. Vincent's and lived across the street from it for two
9 years before we moved up to Naugatuck. We, then, still
10 went back to St. Vincent's for the births of our last two
11 children from Naugatuck.
12 We now live in Wolcott, a little bit
13 closer to Hartford. Again, you say that you're going to
14 be going by the ERDs, however, as a patient, I would be
15 paying into a company that is doing many things that are
16 against my religion. Why shouldn't I go to St. Francis
17 instead? It's not much further from where I live.
18 So those are a few questions. I hope you
19 can answer them. Thank you.
20 MR. PILGRIM: Thank you for the questions,
21 and there are quite a few there, and I think I'm going to
22 let Chad probably close out on some of them.
23 So the specific questions, the ERDs, my
24 first response really is the nature of health care,

1 itself, and that is this is a local business. Tenet
2 Health Corp actually provides no health care. No one
3 shows up at 1445 Ross Avenue in Dallas, Texas with a
4 heart attack, been in a motor vehicle accident, or any
5 other kind of acute event. We do not provide health care
6 at Tenet.
7 We have 79 hospitals that provide health
8 care in the communities they serve, and hospitals occupy
9 a very unique place in the fabric of their communities.
10 They have, in most cases, decades,
11 sometimes centuries of care provided in certain ways,
12 certain heritages associated with those facilities,
13 certain legacy.
14 Our job as an operator of health care is
15 not to disrupt that, not to change that. Our job is, as
16 an operator of hospitals and other health care
17 organizations, is to provide the benefits to scale,
18 simply, to be able to access a supply chain that was
19 mentioned earlier, where we can probably pay 75 cents for
20 a sponge and Chad is paying a buck. It's because of the
21 ability to purchase when you have 79 hospitals, the
22 ability to access IT systems, the ability to access
23 revenue cycle, H.R. systems.
24 We bring the benefits of scale economies

1 to historically very local, very front-facing operations
2 in these communities, without changing the nature of
3 those organizations that serve those communities.
4 You posed some interesting questions. I
5 don't disagree, but I've actually run hospitals, myself.
6 I ran five hospitals in South Texas and San Antonio. It
7 was the Baptist Health System, and when we partnered with
8 the Baptist Health System in 2003, there were several
9 commitments that we made as a part of that transaction,
10 but, first and foremost, on the minds and desires of that
11 Board and of the parent convention was the continuation
12 of the faith-based aspects of that system, very much an
13 organization that was right to life, and we've respected
14 that.
15 In fact, three years into our partnership,
16 we were visited by the Executive Director of the BGCT,
17 the Baptist General Convention, who said, of all of the
18 hospitals, Baptist hospitals in Texas we were doing the
19 Baptist Health Commission better than all the others, and
20 we were the only --
21 As we take the local legacy and the
22 history and heritage of these hospitals extremely
23 seriously, it's very important to Saint Mary's, to the
24 governing Board, to the people that have supported this

1 hospital for the last 110 years, that this hospital
2 continue to be Catholic.
3 It's very important for the people that
4 have supported Waterbury Hospital for the 140 years it
5 served this community for it to continue to serve the
6 community in the ways to manage and serve its community.
7 We believe you can do both. It's a little
8 different than what happened a couple of years ago,
9 because we're actually talking about maintaining separate
10 and distinct campuses and operating them.
11 The question you raise, well, but how can
12 Tenet operate this over here this way and this over here
13 that way? I mean that really makes us not a very and
14 your implication was consistent company. If I'm putting
15 words in your mouth, I don't mean to.
16 And I would submit back to you that our
17 job is to respect the wants and desires of the
18 communities that support those local hospitals, and if a
19 community wants to be faith-based and retain that
20 heritage, then our job is to support it.
21 If a community wants to continue to be
22 secular, if it's the DMC and they're the ground zero for
23 the NIH prenatal site, that's what that community wants,
24 and it's really not -- I think it's not incumbent upon us

1 to change the history or legacy of those organizations.
2 So that's a long answer to a series of I
3 mean really provoking questions. I understand your
4 questions.
5 I'd like Chad to talk a little bit about
6 kind of more specific to the ERDs, because that's not
7 where my expertise is.
8 MR. WABLE: Chad Wable. I'm going to be
9 brief. We are going to follow the ethical and religious
10 directives that the church has set forth, and we're going
11 to do that for as long as we're required to do that.
12 And as those ethical and religious
13 directives change, we're going to adopt whatever those
14 changes are in the ethical and religious directives, and
15 we're going to continue to do the things that we've done
16 for 107 years to protect our Catholic identity and to do
17 the things to respect all of those and the heritage
18 before us.
19 So I can only tell you that we're not
20 going to change the way that we operate, when we operate,
21 you know, the day after we close this transaction.
22 There's not going to be any change in the perspective on
23 that at all. That's what I can tell you, and that's been
24 supported by Tenet, both in the agreement and in the

1 people that you have here before you, people that have
2 run Catholic hospitals, people that have run faith-based
3 hospitals.
4 MR. PILGRIM: Others you raised was some
5 of Tenet's colorful history, and we have had, as a
6 company, a period of time that, you know, it's not
7 something to really be proud of, but it also is something
8 to be very transparent about.
9 In 2002, really it was uncovered by the
10 Federal Government that Tenet was engaged in very
11 aggressive billing practices. They actually didn't break
12 the law in the charge. It was just gaming the system.
13 They did run afoul with some regulations
14 and laws around physician recruitment. That was in
15 Alvarado Hospital in San Diego. And, so, there were
16 sordid issues that that company had, and I'll
17 specifically refer to it as that company, because that
18 company no longer exists.
19 And we went through several years of
20 investigation by the Federal Government. We signed a
21 settlement agreement with the government, was under
22 corporate integrity agreement for five years, but let's
23 talk about what happened and what was done.
24 When this broke in 2002, the Tenet Board

1 elected a new Board Chair, a gentleman by the name of Ed
2 Kangas. Ed lives in Connecticut. He was former Chairman
3 of Deloitte Touche worldwide. He also was the CEO, or,
4 excuse me, on the Board of United Technologies. I guess
5 he still is. He still is on the Board of United
6 Technologies.
7 Ed came in as Chairman. He cleared out
8 the management team. When you have those kinds of issues
9 in the company, there's a cultural problem, and he
10 cleared out the management team, cleared out the Board,
11 brought in a current CEO by the name of Trevor Fetter
12 that didn't reconstitute the management team, and they
13 brought in additional Board members, very impressive
14 Board, and it's a very different company.
15 They embarked upon a journey when Trevor
16 came on in '03 to focus on one thing first, and that was
17 making sure they were given absolutely the highest
18 possible quality of care we could give to our patients,
19 and we're going to do it in a compliant manner.
20 We're going to focus on making sure we
21 were playing the rules, we were going to be compliant,
22 and we were going to give the best patient care, and the
23 belief and the proof is there, as well.
24 If you focused on quality, if you focused

1 on the product you're delivering and you focus on doing
2 it the right way, you know, financial results is a
3 lagging indicator. If you're doing things correctly, the
4 finances will take care of themselves.
5 So they embarked upon a journey to rebuild
6 the company. I was not there. I was at Vanguard. I was
7 part of Vanguard when Tenet acquired Vanguard in October,
8 but it's really an amazing case study if you see what
9 this company has done to come back from the abyss,
10 because that's where it was.
11 Now we are regularly recognized by
12 independent oversight groups as having, you know, best
13 practice compliance, having best practice governance.
14 Now we are a company with 103,000
15 employees. Because we have such a highly-rated and an
16 aggressive compliance program, we're going to find
17 things. People sometimes just don't do what they're
18 supposed to do, and the point of a strong compliance
19 program is find it, identify it, report it, clean it up
20 and move on.
21 It's because of that, yeah, we're going to
22 find things, given the size we are, but it doesn't negate
23 the culture that we've built as a company, and I'll stop
24 at that, because I also would like to say that Mr.

1 Mazaika and this Board, as well as the other volunteer
2 Boards in Connecticut, have spent countless hours, you
3 know, wresting with that same question, investigating us
4 as a partner, because this is a live town.
5 This is a once in a lifetime decision
6 these volunteer Board members are making, and they have
7 not done it precipitously. They have been methodical in
8 their approach, and they've done their homework on us,
9 and we're pretty transparent. We'll open all the books.
10 These are things we've done, but this is
11 where we are, and this is what we've done about, and this
12 is how we fixed it.
13 MR. MAZAIKA: This is Bob Mazaika. To
14 answer your question on Ascension, I guess I apologize if
15 I gave you the impression that Ascension came in second
16 place. They weren't even in the race, and they had
17 formed the for-profit company with a company down in New
18 York, called Oak Hill Partners, and we worked with them
19 for a long time, and, to be perfectly honest with you,
20 they were unable to come up with any transaction that
21 made any financial sense to the task force, so they
22 really were not in the consideration at all.
23 MR. WABLE: This is Chad Wable. To add to
24 that, they actually had voted as a company shortly after

1 leaving the State of Connecticut, and I don't believe
2 they are any longer in existence, the for-profit
3 subsidiary of Ascension.
4 Just for the record, we have talked to
5 every single Catholic health system over the past 10
6 years about potential partnership, so we have had
7 discussions along the way with every single national and
8 regional Catholic system that may be interested in
9 Connecticut, and we explored all those, and there was no
10 interest.
11 SPEAKER CONNOLLY: Okay. Our next speaker
12 is Peter Marcuse.
13 MR. PETER MARCUSE: Thank you. My name is
14 Peter Marcuse. We have lived in Waterbury for over 50
15 years. I've practiced law here for over 20 years, and my
16 concerns with the transaction we're talking about is a
17 fairly fundamental one.
18 It affects in detail the health provision
19 in the City, but it's a financial transaction, and from a
20 legal point of view, at least, it seems to me that there
21 are concerns that we, as citizens of Waterbury, need to
22 deal with that should raise warning flags.
23 Basically, legally, the obligation of
24 Tenet is to its stockholders, and the obligation of Saint

1 Mary's and Waterbury Hospital, of any non-profit, is to
2 present community benefits. That's a big difference, and
3 it can be reflected in a number of ways, and I'd like to
4 raise some of the questions that that brings to my mind.
5 You know, when you speak, as some of you
6 mentioned when you spoke, when you speak of the hospital
7 thriving, thriving and of being concerned with the
8 margins that it produces, thriving means something
9 different for a profit-motivated corporation than it does
10 for a non-profit corporation, and that's so no matter how
11 benevolent the concerns of the leaders or the staff of
12 the for-profit are, it's not a moral reflection on anyone
13 that had tried to make, that he or she tries to make a
14 profit. That's the way the system works and we expect
15 it.
16 So it's not a criticism. It seems to me
17 to be a simple fact, that the motivation, the fundamental
18 motivation is different, and, thus, I'm concerned about
19 the financial implications of what the acquisition would
20 mean.
21 As I see it, the acquisition would lead to
22 some additional costs for the provision of health care in
23 Waterbury.
24 There is an obligation by Tenet to earn

1 enough from the acquisition to compensate its
2 stockholders, to increase the value of its stock. If it
3 is going to raise any of the money that will be involved
4 here and the payments, if it will borrow any of that
5 money, it will need to pay interest on it and dividends
6 on its stock, is that, for each of these, my concern is
7 how will these costs be covered?
8 There will be an increased administrative
9 cost, a whole level of management over and above the
10 existing, which needs to be met.
11 There will be taxes that have to be paid.
12 Real property taxes may be a benefit to the City, but is
13 an expense to Tenet and to the hospital and needs to be
14 covered.
15 There will be a foundation that will have
16 an expanded role. I'm not sure whether it will be the
17 existing foundation or another. Will its functions be
18 governed, also, by Tenet? We've heard about an Advisory
19 Board, but, legally, I see a big difference between an
20 Advisory Board and the Board of Trustees of a foundation,
21 and I'd be interested to know who will appoint the
22 trustees of the foundation and decide how its funds are
23 spent.
24 How will these additional costs be

1 covered? Well I can see several possibilities. One is
2 economies of scale. That's an admitted advantage, but
3 there are economies of scale that have not been grasped
4 over the last many years between the two hospitals in
5 Waterbury. Joint purchasing, for instance. There's no
6 reason, it seems to me, where there are not economies in
7 that way.
8 When I started practicing, we represented
9 a small store that sold appliances, and the first thing
10 that they did was to get together with other appliance
11 stores and pool their wholesale purchasing and then
12 divide it up among them, and that's an obvious
13 efficiency, and it seems to me there are some
14 efficiencies that could be achieved there without a
15 complete sale of assets.
16 Maybe the increase in the efficiencies
17 come from better management. How will better management
18 be put in place? Will Tenet be sending more experienced
19 business managers from Dallas to Waterbury, replacing
20 those here? Are Tenet folks simply smarter than Saint
21 Mary's folk? Why should management be able to do things
22 when it's under Tenet that it cannot do itself?
23 Why cannot all of these improvements and
24 efficiencies now be conducted by the existing management,

1 which I think has done a quite competent job? I think
2 both hospitals in Waterbury are very responsible and very
3 well-respected, not only here, but nationally.
4 I think it needs an argument. It needs
5 proof to show that it could be done better, or perhaps
6 Tenet would cover its additional costs and make the
7 profit that would pay for this acquisition by cutting
8 staff or cutting services, and there the question would
9 be what kind of binding commitments are being made that
10 these investments will, in fact, take place?
11 Won't it be the case that Tenet will have
12 to weigh each of these not so much by what benefit it
13 provides, but by what effect it has on the corporate
14 bottom line. That's its legal responsibility.
15 I'd be interested in knowing what promises
16 have been made, or what representations are made to
17 stockholders of Tenet in justifying its expenditure of
18 Tenet funds, perhaps from equity or increased borrowing.
19 So it seems to me this is not necessarily
20 a criticism of the acquisition, but it certainly seems to
21 me to raise flags, to create a warning.
22 Even if the acquisition goes through, it
23 seems to me a continuing concern, that there is a tension
24 between the goal of increasing profits and the goal of

1 providing community services, a legally-necessary and
2 legitimate tension, but a tension, to -- Tenet speaks of
3 a commitment to Waterbury. That's welcome. It has a
4 commitment to Dallas, as well, and there is a tension
5 between the two, and it seems to me that tension is a
6 matter of significant concern. Thank you.
7 MR. PILGRIM: Trip Pilgrim, Tenet.
8 There's a lot here, and I'll try to make sure we cover
9 all your points, hopefully, at least most of them.
10 In terms of capital access, you're right.
11 We do access the equity markets, in addition to the debt
12 markets and have done for 40-something-plus years as a
13 company, this has been around as a company.
14 But I would take a little issue with the
15 nature of what our focus is as a company, because unlike
16 other companies, we're the only ones that operate
17 buildings where life begins and ends in the four walls,
18 and that is a very different responsibility than if we're
19 manufacturing Toyota Corollas.
20 It's very different if we're operating,
21 you know, what other business, where, you know, the
22 consequences of what we do are just an order of magnitude
23 greater than any other business.
24 The incumbent responsibility that comes

1 with that you describe it as tension, and, you know, I
2 would describe it as, you know, almost a partnership,
3 because if we stay focused on providing quality patient
4 care, taking care of our patients, taking care of their
5 families, taking care of our employees, and we are
6 fanatical about doing that, the financials take care of
7 themselves.
8 Financial results are lagging indicators,
9 sir, and, you know, if we give a bad product -- let's
10 take your example.
11 We come in and, you know, we have to make
12 a bottom line, so, therefore, we're going to cut quality,
13 we're going to cut services, we're going to cut quality,
14 well, still today, the vast majority of physicians in
15 this country are independent private practitioners with a
16 choice.
17 If we have an orthopedic surgeon that
18 comes in and he sees we've replaced a surgical stapler
19 with something seriously inferior, or we've replaced, you
20 know, an implant with something in his mind that is
21 significantly inferior, that physician will take his
22 patients somewhere else.
23 So, you know, you really might save a few
24 pennies this month, but you could realistically end up

1 with an empty hospital next month, and that wouldn't do
2 very well for our bondholders or shareholders either, so
3 quality is actually kind of the focus point for us to
4 drive financial performance.
5 Now we have to be good managers. You have
6 to invest your capital appropriately, prudently, but we
7 invest our capital in a growth model. I want to talk
8 about that just a second, because you mentioned -- I want
9 to get to the additional costs you talked about.
10 We do not pay dividends as a public
11 company. We never have paid dividends. Our investors
12 invest in the company to get share appreciation. They
13 want to see the company's value grow, and the way we grow
14 value in a company is to focus on growing our services
15 and growing our markets.
16 That's why we want to invest 85 million
17 dollars in Waterbury Connecticut. That's why we've
18 committed to 50 million dollars in or 75 million dollars
19 in Manchester and in Rockville and 45 million in Bristol.
20 That's why we spent 400 million in San
21 Antonio, Texas. This is why we've committed 850 million
22 on Detroit, Michigan, because we know that if you invest
23 in the right configuration of facilities and technology,
24 that it's going to yield you an opportunity to grow your

1 business. You're going to attract the best and the
2 brightest.
3 If I'm a rock star neurosurgeon coming out
4 of a fellowship at Mass General, do I want to go to a
5 facility that doesn't have, you know, an interoperative
6 MRI with the kind of microscope I want, or do I want to
7 go to a facility that does have it? Obviously, you're
8 going to want to go to the one that does have it, so we
9 want to make sure that we can invest and configure these
10 hospitals, because we want to grow our business, and then
11 we can return, the returns we can give our investors are
12 then predicated on that growth.
13 You mentioned additional cost. I'll let
14 Erik talk a little bit about on a go-forward basis, but,
15 first and foremost, we don't have to finance this
16 transaction.
17 We have the cash available on our current
18 balance sheet, so we don't have to -- there's no
19 incremental interest expense associated. There's no
20 interest cost associated with doing the transaction.
21 You mentioned additional administrative
22 expenses. The actuality is the opposite. We're able to
23 drive a number of administrative efficiencies through our
24 H.R. systems, through our finance and accounting systems,

1 for our revenue cycle systems, and another system that we
2 really kind of dodged around tonight is IT.
3 Chad did, I think, a very great job
4 articulating how we are migrating from this old the more
5 you do the more you make into, you know, we're going to
6 be rewarded and compensated, based upon how well we do
7 and how efficiently we do it, but you can't make that
8 migration without really having a fairly substantive
9 shift in the information technology infrastructure under
10 all of that, to be able to provide, you know, clinical
11 integration.
12 Real-time management of clinical care
13 requires a whole mountain of investment that a
14 freestanding community hospital can't afford, so we're
15 able to leverage lot of these costs over 79 hospitals, so
16 there's not, you know, there's not additional
17 administrative costs associated with doing the
18 transaction.
19 And, then, on a go-forward basis, you
20 talked about why, you know, on the supply chain in
21 Waterbury and Saint Mary's, you'd be able to take
22 advantage of that now. How are they going to do it?
23 Erik can tell you a little bit about, you
24 know, kind of how we achieve those economies on a month-

1 to-month kind of operating basis.
2 MR. WEXLER: Thanks, Trip, and thanks for
3 your very deep thought into the questions you asked
4 tonight. I appreciated that a lot.
5 I just want to perhaps relate to you I
6 might be the best person in the room to describe the
7 differences between the not-for-profit world and the for-
8 profit world, because I spent 18 years on the not-for-
9 profit side of things before I moved into the
10 investor/owner for-profit side of things three years ago,
11 and I have to tell you I don't see too many differences.
12 Yes, we pay taxes. Yes, we have to earn
13 profits, but I was always on the not-for-profit side,
14 whether I worked here in Waterbury, or MidState Medical
15 Center for the Hartford Health Care System, or in
16 Baltimore for LifeBridge Health, all not-for-profit.
17 We always had to work to have a bottom
18 line, so that we could reinvest in our facilities, and,
19 so, what I'm telling you is my experience so far on the
20 for-profit side is that drive is still there, but I can
21 tell you this, that the stakes are higher for us perhaps
22 in the investor-owned space, because if we don't have
23 high quality service and high quality care, our patients
24 and, as Trip said, our physicians go away, and there goes

1 the profit, and there goes our institutions, and our
2 stock will go down, and we will fail, so we are driven
3 for quality.
4 Trip can talk about his years in San
5 Antonio, and I love talking about my years in Worcester,
6 not far from here. St. Vincent Hospital is a top 100
7 hospital in the United States, is also known as the top
8 50 for cardiovascular care, and it is a high value
9 institution.
10 And what that means is we've been able to
11 bring our costs down to make our margin and still deliver
12 quality. We are one of the few hospitals in the
13 Commonwealth of Massachusetts that is tier one in every
14 single health plan, because we are high value, low cost
15 and high quality.
16 In terms of the economies of scale Trip
17 was referring to, I think that what we would be able to
18 offer Chad and his team and the other hospitals in
19 Connecticut is access to the scale that you described in
20 some of your comments and Trip described, but in offering
21 a level of expertise for how you get it, things that you
22 didn't really know about, because I remember my days
23 working for independent health systems.
24 I could go to the Connecticut Hospital

1 Association, or something called the Advisory Board in
2 Washington, D.C., or the Volunteer Hospital Association,
3 which is one of our buying networks, and ask for advice
4 and opinion, but I can tell you that since I've been part
5 of Vanguard, which is 28 hospitals and now Tenet 80
6 hospitals, I have access to data immediately, deep,
7 robust data that helps me manage my hospitals like I
8 never had before.
9 So I hope those help relate my experience,
10 but one last thing when it comes to local management.
11 You said something that was very important.
12 You have good people here at Saint Mary's
13 Hospital, and I am extremely impressed with the team that
14 Chad has put together at the leadership level. That's
15 most of the people that I've met so far.
16 We want to keep those people in place.
17 Our hospitals have CFOs and CNOs and CMOs and CEOs, the
18 same team that you have here. Those positions are
19 represented, because we think that local management is
20 very important to the ability of a hospital to be
21 successful, but what we want to do is provide leadership,
22 so that they have the robust data that they need to be
23 even more successful than they are today.
24 MR. MAZAIKA: Bob Mazaika. You raised the

1 issue on the foundation. The foundation will be a
2 separate organization. It has no attachment or anything
3 with Tenet. It will be run by local people, and it will
4 be basically probably the largest foundations certainly
5 in the Waterbury area, if not, in the State of
6 Connecticut, and the Board of that foundation will be
7 local people, much like the Saint Mary's Board has been.
8 SPEAKER CONNOLLY: All set, gentlemen?
9 Okay. Thank you very much. Pardon me? No comment?
10 MR. MARCUSE: Two formulations. One is,
11 if Tenet doesn't pay dividends, but looks for increase in
12 stock value, how do you measure the increase in stock
13 value?
14 The other question is for a non-profit as
15 opposed to a profit-making company. How do you decide
16 whether to invest in new facilities or not, by what
17 measure?
18 MR. WABLE: I can address the latter
19 portion of your question. Chad Wable. The latter
20 question. This is Cad Wable.
21 You know, right now, not-for-profit
22 hospitals have almost no access to capital. Cost of
23 capital is high, so we'd have to go to the tax-exempt
24 bond market if we were able to borrow. That's if we were

1 able to borrow.
2 Now you've got Moody's with the negative
3 outlook that I mentioned, so a lot of obstacles in trying
4 to do that.
5 What we would do right now is we would
6 have to generate cash from operations, in order to fund
7 facility improvements, and, so, that's the way we've been
8 operating over the most recent several years.
9 And, so, the funds that we would generate
10 would go back towards improving the facilities clinical
11 technology, information technology, all those things that
12 I listed for you. Physician integration, ambulatory care
13 network development, all of those would compete for
14 funds, and it would be very hard to fund all of the
15 capital needs in all of those areas, and it is each and
16 every year.
17 MR. MARCUSE: You need to stay in the
18 black, but you don't need to make a profit.
19 MR. WABLE: This is Chad Wable. I would
20 say that we'd definitely need to make a certain profit,
21 and we'd definitely need to have a certain margin, in
22 order to reinvest back in talent and back into facilities
23 and back into the clinical capital.
24 Not having a margin would leave us very

1 little ability to reinvest in Saint Mary's, thus, over
2 time, reducing quality and reducing service, and that's
3 not the direction that we're looking to go in.
4 SPEAKER CONNOLLY: Thank you very much.
5 Our next speaker is Steve Schrag.
6 MR. STEVE SCHRAG: Good evening. My name
7 is Steve Schrag. I live at 14 Quentin Street here in
8 Waterbury, and, over the last three years, we've been
9 looking at the issues of our two hospitals and our
10 concern about maintaining the quality that we get out of
11 our non-profit hospitals.
12 We have heard you say that you support
13 things like maintaining quality care, charity care, good
14 quality jobs, and transparency of operations. We think
15 that's terrific, so why are we concerned?
16 Because these are lots of promises about
17 the future, but without a written agreement what do they
18 mean?
19 Once upon a time in Waterbury, we had tens
20 of thousands of brass jobs in this community owned by
21 local businesses. National corporations came in and
22 bought them all and made promises then, too. Those jobs
23 are all gone now.
24 Stop signs, street lights and police

1 reduce the chaos that our streets have. We need the same
2 kind of protections for our health care system, and we
3 believe a community benefits agreement will help make
4 that a reality.
5 Ironically, I'm going to quote Ronald
6 Reagan, who once said, "Trust, but verify," and that's
7 why we want a community benefits agreement if you shift
8 from a non-profit to a for-profit hospital. Thank you.
9 SPEAKER CONNOLLY: Okay. I believe that's
10 our last speaker for this evening, so thank you, all,
11 very much for attending, thank you for your attention,
12 and that will wrap up our meeting. Goodnight.
13 (Whereupon, the hearing adjourned at 7:15
14 p.m.)

RE: SAINT MARY'S HEALTH SYSTEM & TENET HEALTHCARE
JULY 28, 2014

AGENDA

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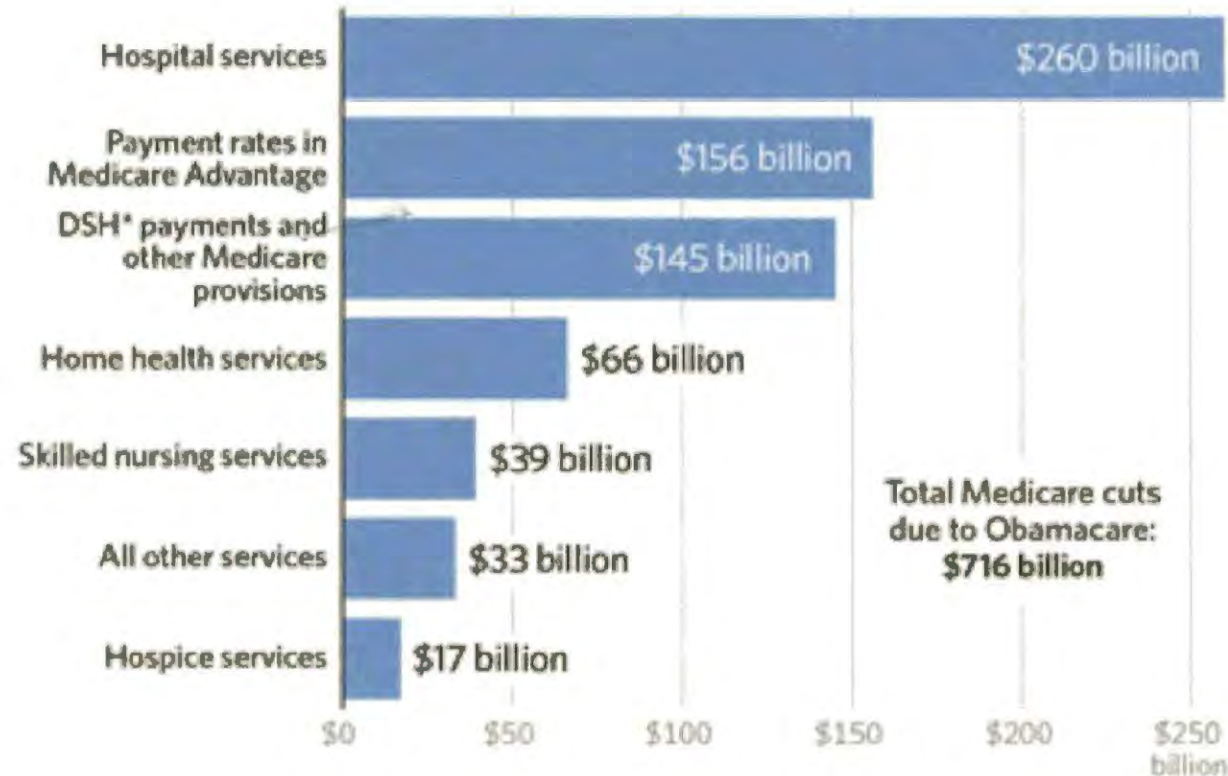
Projected Cuts in Medicare Funding 2013-2022



Sources: Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Speaker John Boehner, U.S. House of Representatives, July 24, 2012, pp. 13-14, and Douglas W. Elmendorf, Director, Congressional Budget Office, letter to the Honorable Jeff Sessions, U.S. Senate, January 22, 2010, p. 3.

Saint Mary's HOSPITAL Tenet

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Saint Mary's
HEALTH SYSTEM

OUTPATIENT SERVICES GUIDE

	Saint Mary's Hospital	Saint Mary's Blood Draw Waterbury Watertown Southbury	Saint Mary's Medical Imaging Center	Naugatuck Urgent Care Center	Wolcott Urgent Care Center	West Main Health & Wellness Center	Cardiovascular Diagnostic Center	Occupational Health & Diagnostic Center	Saint Mary's Outpatient Center – East Main Street	Diagnostic Imaging of Southbury	Naugatuck Valley Surgical Center
IMAGING SERVICES											
Cat Scan	●									●	
Bone Densitometry (DEXA)	●									●	
Interventional Radiology	●										
Digital Mammography	●									●	
MRI	●		●							●	
Nuclear Medicine	●						●			●	
Ultrasound	●									●	
Carotid Ultrasound							●				
X-Ray	●			●	●			●	●	●	
CARDIAC TESTING											
Cardiac Cath/PTCA	●										
Echocardiography	●						●				
EKG	●			●	●						
Holter Monitoring	●						●			●	
Pacemaker Implantation	●										
Stress Testing	●						●			●	
OTHER SERVICES											
Ambulatory Surgery	●										●
EEG	●										
EMG	●										
Occupational Health								●			
Physical Therapy				●							
Pulmonary Testing	●										
Sleep Lab					●	●					
Urgent Care				●	●						
Wound Care/HBO	●					●					
Outpatient Behavioral Health	●										
LAB/BLOOD DRAW	●	●		●	●		●		●		

Saint Mary's Hospital 56 Franklin Street, Waterbury
Central Scheduling: .... (203) 709-8601 .... fax: (203) 709-8602
[CT, ECHO, EEG, Holter Monitoring, Mammography, Nuclear Medicine, Pulmonary Testing, Stress Testing, Ultrasound, X-Ray, Cath Lab, MRI]
MRI: .... (203) 709-7674 .... fax: (203) 709-7676
Interventional Radiology: .... (203) 709-6448 .... fax: (203) 709-7061
EMG: .... (203) 753-6004 .... fax: (203) 709-8844
Ambulatory Surgery: .... (203) 709-6096 .... fax: (203) 709-3525
Wound Healing Center: .... (203) 709-3000 .... fax: (203) 709-3070
Cardiac Cath/PTCA: .... (203) 709-6365 .... fax: (203) 709-8731

Saint Mary's Hospital Blood Draws
Medical Office Building
133 Scovill Street, Waterbury .... (203) 709-3660 .... fax: (203) 709-8735
Saint Mary's Outpatient Centers
1981 East Main Street, Waterbury .... (203) 709-6052 .... fax: (203) 709-6057
Union Square, Southbury .... (203) 267-5611 .... fax: (203) 267-5640
70 Hemingway Park Road, Watertown .... (203) 709-5931 .... fax: (203) 709-5958

Saint Mary's Medical Imaging Center
475 Chase Parkway, Waterbury .... (203) 709-5550 .... fax: (203) 709-5555

Saint Mary's Outpatient Center
1981 East Main Street, Waterbury .... (203) 709-6052 .... fax: (203) 709-6057

Saint Mary's Outpatient Behavioral Health Services
100 Jefferson Square, Waterbury .... (203) 709-6201 .... fax: (203) 709-3335

Naugatuck Urgent Care Center 799 New Haven Road, Crosspointe Plaza, Naugatuck
Urgent Care Center: .... (203) 723-5636 .... fax: (203) 723-5634
Physical Therapy: .... (203) 720-1750 .... fax: (203) 720-1793

Wolcott Urgent Care Center 503 Wolcott Road, Wolcott
Urgent Care Center: .... (203) 879-7900 .... fax: (203) 879-7979
Sleep Lab: .... (203) 879-7983 .... fax: (203) 879-7989

West Main Health & Wellness Center 1312 West Main Street, Waterbury
Sleep Lab: .... (203) 709-6243 .... fax: (203) 709-4550
Physical Therapy: .... (203) 709-6232 .... fax: (203) 709-7764

Cardiovascular Diagnostic Center
1320 West Main Street, Waterbury .... (203) 709-7300 .... fax: (203) 709-4501

Occupational Health & Diagnostic Center
146 Highland Avenue, Waterbury .... (203) 709-3740 .... fax: (203) 709-3741

Diagnostic Imaging Of Southbury *(a partnership with NVRA)*
Union Square, Southbury .... (203) 267-5800 .... fax: (203) 267-5801

Naugatuck Valley Surgical Center
160 Robbins Street, Waterbury .... (203) 755-6663 .... fax: (203) 756-9645

Revised January 2014

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Saint Mary's Hospital

CHNA IMPLEMENTATION STRATEGY

BACKGROUND

Saint Mary's Hospital has served the city of Waterbury since 1907, when it was founded by the Sisters of Saint Joseph of Chambery. The founding of the hospital was made possible by a generous donation by the Right Reverend Monsignor William J. Slocum. In its first year, Saint Mary's Hospital was a 120 bed facility and had a staff of 14. It is now licensed for 347 beds and employs more than 1,800 people. The mission of Saint Mary's Hospital is to provide excellent healthcare in a spiritually enriched environment to improve the health of our community. The vision of Saint Mary's Hospital is to be the leading regional healthcare provider. Saint Mary's Hospital values are:

- Integrity: Commitment to doing what is right
- Caring: Compassionate approach to addressing the healthcare needs of all people
- Accountability: Personal responsibility for the performance of Saint Mary's Health System
- Respect: Respect for the dignity, worth, and rights of others
- Excellence: Working together in pursuit of superior clinical quality and service to others

Saint Mary's Hospital serves the city of Waterbury and 17 surrounding towns. In 2013, Saint Mary's Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in these communities. The CHNA was done in collaboration with The Greater Waterbury Health Improvement Partnership. The partnership consists of Saint Mary's Hospital, Waterbury Hospital, Waterbury Department of Public Health, the City of Waterbury, StayWell Health Center, Connecticut Community Foundation, United Way, and other community organizations. Saint Mary's Hospital views community health improvement as an ongoing effort that requires leadership through example and partnership with other community organizations to improve the health status and quality of life of community residents.

The purpose of the assessment was to gather information about health needs and behaviors. A variety of indicators were examined including risky health behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). The current assessment will guide Saint Mary's ongoing work to improve community health and comply with new requirements for tax-exempt health care organizations to conduct a CHNA and adopt an Implementation Strategy aligned with identified community needs.

THE CHNA PROCESS

Saint Mary's Hospital contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. A comprehensive CHNA was conducted and included a variety of quantitative and qualitative research components. These components included the following:

1. Secondary Data Profile
2. Statistical Household Survey
3. Focus Groups
4. Key Informant Interviews
5. Prioritization of Community Needs
6. Implementation Strategy

Holleran compiled a **Secondary Data Profile** using data collected from sources such as the U.S. Census Bureau, Waterbury Department of Public Health, Connecticut Department of Health, and Centers for Disease Control and Prevention, among others. The report depicts the most recent year health indicators, census figures, household statistics, morbidity and mortality rates, and socioeconomic measures for the city.

A **Statistical Household Survey** was completed with 1,100 community residents. The survey aligns with the Behavioral Risk Factor Surveillance System (BRFSS) study promoted by the Centers for Disease Control and Prevention (CDC). The survey assessed indicators such as general health status, prevention activities (screenings, etc.), and risky behaviors (alcohol use, etc.). The results were examined by a variety of demographic indicators including age and gender. Special attention was given to identifying the needs of underserved individuals, including low-income, minority, and chronic condition populations in the county.

Holleran conducted six **Focus Groups** to better understand health issues related to access to care, health education/communication, healthy behaviors, and community health infrastructure. A total of 24 health care providers and 33 community residents participated in the six focus groups. Holleran analyzed the results of the findings to determine commonalities between populations and uncover themes to aid Saint Mary's Hospital in addressing the identified barriers.

A **Prioritization Session** was held on June 18, 2013. Approximately 40 individuals representing the Greater Waterbury Health Improvement Partnership gathered to review the results of the 2013 Community Health Needs Assessment (CHNA) and prioritize key health needs. Among the attendees were representatives from local health and human service agencies, area non-profit organizations, health providers, and public health representatives. Please see Appendix A for a listing of individuals who attended the session.

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Saint Mary's Hospital developed an **Implementation Strategy** to outline what community health needs it plans to address, as well as specific goals and measures to evaluate community health improvement initiatives.

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

In June 2013, individuals from healthcare organizations, community agencies, social service organizations, and area non-profits gathered to review the results of the CHNA data. The planning meeting was initiated by partners of the the Greater Waterbury Health Improvement Partnership, including Saint Mary's Hospital. The goal of the meeting was to discuss CHNA findings in an effort to prioritize key community health issues.

The objectives of the session were:

- To review recently compiled community health data and highlight key research findings;
- To gather feedback from community representatives about community health needs;
- To prioritize the community health needs based on select criteria.

Prioritization Process

Holleran Consulting facilitated the prioritization session. The meeting began with an abbreviated research overview, including the results of the primary and secondary research and key findings of the CHNA.

Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. In a large-group format, attendees were asked to share openly what they perceived to be the needs and areas of opportunity in the community. Through facilitated discussion, attendees developed the following "Master List" of potential priority areas.

Master list of community priorities (in alphabetical order)

- Access To Care
- Cancer
- Diabetes
- Heart Disease
- Infant Mortality/Low Birth Weight
- Mental Health/Substance Abuse
- Overweight/Obesity
- Respiratory Disease
- Smoking

Key Community Health Issues

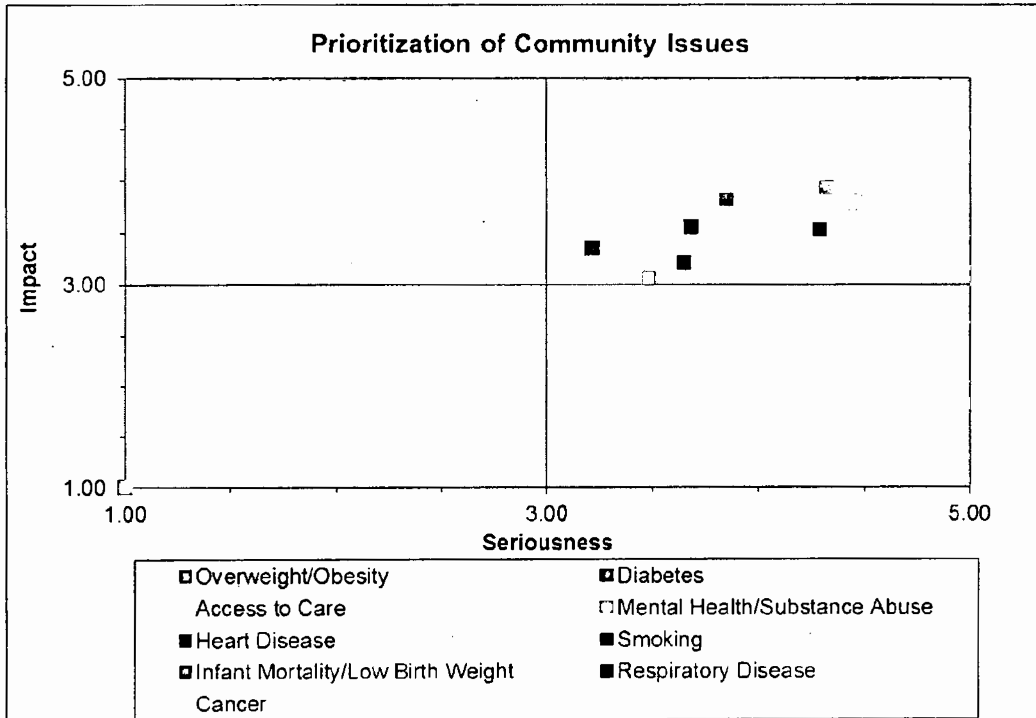
Once the Master List was compiled, participants were asked to rate each need based on two criteria. The two criteria included the "seriousness of the issue" and the "community's ability to impact the issue." Respondents were asked to rate each issue on a scale of 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact). The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee

received a keypad to register their vote. The following table reveals the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health/Substance Abuse	4.76	3.76	4.25
Overweight/Obesity	4.32	3.94	4.13
Access to Care	4.45	3.79	4.12
Smoking	4.29	3.53	3.91
Diabetes	3.85	3.82	3.84
Heart Disease	3.68	3.56	3.62
Respiratory Disease	3.65	3.21	3.43
Infant Mortality/Low Birth Weight	3.21	3.35	3.28
Cancer	3.48	3.06	3.27

The priority area that was perceived as the most serious was Mental Health and Substance Abuse (4.76), followed by Access to Care (4.45), and Overweight and Obesity (4.32). The ability to impact Overweight and Obesity was rated the highest (3.94), followed by Diabetes (3.82), and Access to Care (3.79).

The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Identified Health Priorities

Attendees reviewed the findings from the voting and discussed cross-cutting approaches to further hone the priority areas. Ultimately, the following four priority areas for Waterbury were adopted:

- Access to Care
- Mental Health/Substance Abuse
- Chronic Disease (Obesity, Diabetes, Heart Disease and Asthma)
- Smoking

STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

Saint Mary's Hospital developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the executive team and board of directors. The goal statements, objectives and initiatives, and inventory of existing community assets and resources for each of the four priority areas are listed below.

I. Access to Care

Goal: Improve access to comprehensive, culturally competent, quality health services.

Objectives:

- Increase the proportion of patients with health insurance
- Increase the proportion of persons who have a specific source of ongoing care

Key Indicators:

- Number of uninsured patients approved for health insurance programs
- Number of patients who report having a primary care provider
- Number of patients participating in the Children & Youth Medical Home Initiative

Existing Programs

Hospital-Based Access to Care Programs

- Saint Mary's has patient financial advocates who help patients qualify for insurance programs such as Medicaid. In 2012, these advocates assisted 656 individuals in obtaining insurance coverage.

Grant-Funded

- Saint Mary's has received grant funding from the Connecticut Department of Public Health for the Children and Youth with Special Health Care Needs Medical Home. This Medical Home develops care plans and provides healthcare for children and youth with chronic physical and/or behavioral issues.
- Saint Mary's has grant funding from the Connecticut Department of Public Health for the Connecticut Cancer and Heart Disease Integrated Health Screening program (CHDIHS), which was formerly known as the Breast and Cervical Grant. This program provides screening for breast and cervical cancer and if a cancer is diagnosed through the grant, funds are available for treatment. CHDIHS recently integrated a colorectal screening component.
- Saint Mary's Children's and Family Health Center, Dental Clinic and Outpatient Behavioral Health Center provide services to patients who are uninsured, under-insured or have

Medicaid. Thousands of patients receive services through these clinics; these clinics have over 50,000 visits per year.

Initiatives

- Collaborate with the Connecticut Health Insurance Exchange to help residents gain access to health insurance.
- Evaluate opportunities to improve access to primary and urgent care.
- Enhance cost estimate and insurance verification programs so patients can better understand financial responsibilities in advance.
- Provide appropriate technology in hospital to enhance patient experience across multiple settings.
- Educate health care providers on resources (e.g., Malta House of Care) for uninsured/underinsured and low income patients and families.
- Develop nurse navigator programs where appropriate to improve access to primary care and behavioral health.

Existing Community Resources

Chase Family Resource Center
Community Health Centers, Inc.
Malta House of Care
New Opportunities, Inc.
StayWell Health Center, Inc.
Waterbury Health Access Program
Waterbury Department of Public Health

II. Mental Health and Substance Abuse

Goal: Improve mental health and reduce substance abuse through awareness, access to services, and promoting positive environments.

Objectives:

- Increase the proportion of adults with mental health disorders and/or substance abuse who receive treatment
- Increase mental health and substance abuse screening by primary care providers
- Increase number of points of access for referral to services

Key Indicators

- Number and percent of patients in the Emergency Department whose primary diagnosis is related to mental / behavioral health.
- Length of stay in ED for mental / behavioral health patients.
- Number of ED referrals for mental / behavioral health care services.

Existing Programs

- Saint Mary's has a twelve-bed inpatient psychiatric unit. In FY 12, 611 patients were discharged from the unit. The average length of stay in the unit is 6.36 days.
- Saint Mary's has an intensive outpatient behavioral health program. Approximately, 1,800 patients receive services through this program each year.
- Saint Mary's Emergency Department is a resource for patients with behavioral health needs. In 2012, 11,163 ED patients had a primary diagnosis related to behavioral health. These patients represent 16% of total visits (70,067). The average length of stay for behavioral health patients in the ED was 38.4 hours or 1.6 days. Some of the ED behavioral health patients receive services in the seven-bed behavioral health holding unit.

Initiatives

- Evaluate options to enhance Behavioral Health unit in the Emergency Department to better meet patient needs.
- Analyze potential for development of a Community Crisis Center or Behavioral Health Walk In Center.
- Evaluate options to develop a Geriatric Emergency Department Program to reduce unnecessary ED utilization.
- Continue to participate in the Connecticut Behavioral Health Partnership, which is organized through ValueOptions.
- Evaluate Community Care Team program based at Middlesex Hospital and determine if a similar model could work in Waterbury.
- Evaluate potential for an ambulatory detoxification program.

Resources

Catholic Family Services
Community Health Centers, Inc.
Family Services of Greater Waterbury
Home to Home Foundation
Neighborhood Housing Services of Waterbury
StayWell Health Center, Inc.
Visiting Nurses Association
Waterbury Department of Public Health
Waterbury Youth Services
Wellmore Behavioral Health

III. Chronic Diseases (Obesity, Heart Disease, Diabetes, and Asthma)

Goal: Promote health and reduce chronic disease through healthy eating and physical activity

Objectives:

- Reduce percent of overweight and obese residents
- Increase access and consumption of healthy foods
- Increase food security by addressing/reducing hunger
- Reduce risk factors for chronic disease

Indicators:

- Number and percent of patients who are obese or overweight at the time of their visit.
- Number and percent of patients receiving inpatient and outpatient nutritional counseling.
- Number of children in the Early Obesity Prevention Program that demonstrate improved weight.
- Number of children who receive meals through the Health Nutrition Grant.
- Number of physicians participating in the Easy Breathing Program.
- Number and percent of hospital meals that meet Sodexo's Mindful Meal Selection Program.
- Number and percent of residents utilizing the farmer's market who report increased consumption of fruits and vegetables.
- Number of food prescriptions written.

Existing Programs

Obesity and Heart Disease

- Saint Mary's offers inpatient and outpatient nutritional counseling.
- Saint Mary's has a bariatric program. Services offered through the program include monthly educational seminars, nutritional counseling, gastric bypass and gastric banding surgery, and support groups. In FY 2012, 112 patients had obesity surgery.
- Saint Mary's works with community organizations on the Early Childhood Obesity Prevention Program. This program is funded by Saint Mary's Hospital, the Connecticut Community Foundation and the American Heart Association. The grant is in its first phase to collect local data on childhood obesity. The second phase will include developing interventions to reduce obesity.
- Saint Mary's Children's Development Center has a Bureau of Health Nutrition Grant to provide lunch and snacks for children who live in poverty. This grant is partially funded by the Department of Education.
- Food services at Saint Mary's are provided by Sodexo. Sodexo offers a Mindful Meal Program that includes low calorie and low fat healthy food options.

Asthma and Diabetes

- The Easy Breathing program works to inform physician practices and foster a community-based approach to pediatric asthma and review program data at the community level.
- The Connecticut Community Foundation and the American Hospital Association has awarded Saint Mary's a grant for diabetes education in the Naugatuck area. This is collaboration with the Heart Center of Greater Waterbury.

Initiatives

- Collaborate with Brass City Harvest to offer a farmer's market.
- Evaluate ways to continue to improve meal choices at the hospital.
- Support the Waterbury Department of Public Health's food and nutrition programs (such as the Healthy Corner Stores Initiative Food Prescription Programs).
- Participate in the American Heart Association Mission Lifeline Program.
- Determine possibility of holding community education and screening events in collaboration with local providers.
- Provide nurse educator to patients with Congestive Heart Failure to coordinate post-acute care services and provide patient and family education.

Resources

- Brass City Harvest
- Bridge to Success Community Partnership
- Community Health Centers, Inc.
- End Hunger Connecticut
- Heart Center of Greater Waterbury
- New Opportunities, Inc.
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

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IV. Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.

Objectives:

- Reduce smoking and overall tobacco use among adults, adolescents and children
- Reduce the initiation of tobacco use among children, adolescents, and young adults
- Increase smoking cessation attempts and recent successes by smokers
- Increase tobacco screening, counseling, and education about health risks of using tobacco
- Increase tobacco free environments

Key Indicators

- Number of people participating in smoking cessation programs and percent that successfully quit smoking.
- Number of patients who receive smoking cessation counseling.

Existing Programs

- The American Lung Association has awarded Saint Mary's tobacco cessation funds. Funds are currently available to cessation classes.
- All patients who are discharged from Saint Mary's Hospital receive Smoking Cessation educational materials in their discharge packets.

Initiatives

- Work with Harold Leever Regional Cancer Center to enhance smoking cessation program.
- Evaluate opportunities to pilot incentive program to increase smoking cessation rates.

Resources

- Community Health Centers, Inc.
- Harold Leever Regional Cancer Center
- Public and Private School Systems
- StayWell Health Center, Inc.
- Waterbury Department of Public Health

RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED

Saint Mary's Hospital plans to address all four of the prioritized community health needs identified through the 2013 Community Health Needs Assessment and prioritized by community representatives.

APPROVAL FROM GOVERNING BODY

The Saint Mary's Hospital Board of Directors met on September 12, 2013 to review the findings of the CHNA and the recommended Implementation Strategy. The board voted to adopt the Implementation Strategy and provide the necessary resources and support to carry out the initiatives therein.

Appendix E: Prioritization Session Participants – June 18, 2013

Name	Title	Organization
Maryangela Amendola	Director	Chase Family Resource Center
John Bayusik	Emergency Preparedness Coordinator	Waterbury Health Department
Christine Bianchi, MSW, LCSW	Chief Development Officer	StayWell Health Center, Inc.
Kathy Caiazzo	Commissioner	Waterbury Board of Public Health
Ellen Carter	Program Officer	Connecticut Community Foundation
Juana Clarke	Director of Grants & Operations Audit	Waterbury Hospital
Dawn Crayco	Deputy Director	End Hunger Connecticut
Anthony Cusano, MD	Physician	Waterbury Hospital
Sam D'Ambrosi	President	Board of Health
Jennifer DeWitt	Director	CNV Regional Action Council
John DiCarlo	Public Policy, Economic Development Director	Chamber of Commerce
Rachel DiVenere	Public Health Educator	Waterbury Health Department
Doreen J. Elnitsky	Administrative Director of Behavioral Health	Waterbury Hospital
Pat Evans	Grants Manager	Saint Mary's Hospital
Blair Foley	Director	Home-to-Home Foundation
Natalie Forbes	Grant Writer	Waterbury Hospital
Anne Marie Garrison	VP Clinical Operations	VNA Health-at-Home
Elizabeth George	Student Intern	Yale University School of Public Health
Michael A. Gurecka	Director of Business Development	New Opportunities, Inc.
Lori Hart	Director	Bridge to Success
Silvia Hutcheson	Director of Strategic Planning & Business Development	Saint Mary's Hospital
Celeste Karpow	Student Intern	UCONN School of Public Health
Michele Kieras	Provider Liaison	VNA Healthcare
Kevin Kniery	Director	Harold Leever Cancer Center
Kathy Lang	Clinical Director, Meriden, Waterbury	Catholic Charities Archdiocese of Hartford
Shpetim Mete	Physical Education Teacher	Driggs Elementary School Waterbury
Sandra Micalizzi, APRN	Clinical Nurse Specialist	Heart Center of Greater Waterbury
Justine Micalizzi	Community Engagement Coordinator	Benchmark Senior Living

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Lois Mulhern	Nursing Supervisor	Waterbury Health Department of Public Health
Kathleen Novak	Policy Development	Waterbury Health Department
Deb Parkinson	Operations Manager	Harold Leever Cancer Center
Sandy Porteus	Director	Family Services of Greater Waterbury
Owen Quinn	Director of Housing	New Opportunities, Inc.
Bill Quinn	Director	Waterbury Health Department
JoAnn Reynolds-Balanda	VP Community Impact	United Way of Greater Waterbury
Darlene Stromstad	President & Chief Executive Officer	Waterbury Hospital
Peg Tentoni	Regional Director Clinical Op	VNA Healthcare
Nicole Theriault	Nutritionist	Brass City Harvest
Paula Van Ness	President & Chief Executive Officer	Connecticut Community Foundation
Yadiris Vega	Volunteer	Bridge to Success
Barbara White	Marketing Manager	Saint Mary's Hospital

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Saint Mary's Health System, Inc. and Saint Mary's Hospital, Inc.
Boards of Directors
Thursday, September 12, 2013

Present
Most Rev. Henry J. Mansell, Chair
S. Mark Albini, M.D.
Joseph Carlson (via phone)
Rev. Monsignor James Coleman
Stephen R. Griffin, Esq. (via phone)
Michael Karnasiewicz, M.D.
Sister Dolores Lahr, CSJ
Joseph Mengacci, Esq.
William Morris
Michael O'Brien
David Robinson
Robert Roscoe
Jerry Sugar, M.D.
Christine Sullivan, Esq.
James Uberti, M.D.
Chad W. Wable
Linda Wihbey, Esq.

Staff Present
Robert J. Anthony, Esq.
Victoria Cipriano
Bob Riley
Steve Schneider, M.D.

Joe Connolly:
Auxiliary Report and CHNA

Excused
Garrett Casey
Jim Smith

I. **Call to Order & Opening Prayer**

REDACTED

REDACTED

V. Report of the President

Community Health Needs Assessment (CHNA)

J. Connolly referred the Board to a draft copy of Saint Mary's Community Health Needs Assessment (CHNA) behind Tab 5 and provided an overview of the CHNA. Mr. Connolly advised that the IRS requires tax-exempt hospitals to conduct a community health needs assessment in collaboration with community organizations. The CHNA needs to include an implementation strategy that identifies the needs in the community and how the hospital plans to address the needs. The CHNA and implementation strategy needs to be approved by the Board by September 30, 2013 and needs to be completed every 3 years. Tax-exempt hospitals that choose not to conduct a CHNA face a $50,000 per year fine.

Mr. Connolly advised that several organizations began meeting in 2011 to plan the CHNA. The organizations included SMH, Waterbury Hospital, Waterbury Department of Public Health, United Way of Greater Waterbury, StayWell Health Center and Connecticut Community Foundation. Organization came together as the Greater Waterbury Health Improvement Partnership (GWHIP). Mr. Connolly also advised that hired Holleran to conduct the assessment and facilitation prioritization of community health needs. All 6 organizations contributed financial resources towards the assessment. Mr. Connolly discussed the CHNA process in Waterbury. He provided findings and selection of Community Health priorities. He reported the top 4 priorities selected by the group include Access to Care, Mental Health/Substance Abuse, Chronic Diseases (diabetes, heart disease, obesity and asthma) and smoking. Mr. Connolly provided SMH's implementation addressing community health needs. A discussion ensued.

Motion: Motion made, seconded, and carried to approve the Community Health Needs Assessment (CHNA).

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Operating Expense W/O Bad Debts per Equivalent Case - Adjusted by CMI

	Hospitals	FY 2010	FY 2011	FY 2012
1	Bridgeport Hospital	$8,168	$8,578	$8,783
2	Bristol Hospital	$5,864	$5,757	$5,575
3	Connecticut Children's Medical Center	$12,448	$13,626	$13,305
4	Danbury Hospital	$8,914	$9,155	$9,398
5	Day Kimball Hospital	$6,522	$7,278	$6,504
6	Greenwich Hospital	$8,470	$8,747	$9,512
7	Griffin Hospital	$7,177	$8,298	$8,181
8	Hartford Hospital	$9,965	$10,171	$10,341
9	Hospital of Saint Raphael	$9,060	$9,425	N/A
10	John Dempsey Hospital	$9,437	$9,863	$10,657
11	Johnson Memorial	$6,911	$6,753	$7,093
12	Lawrence & Memorial Hospital	$7,199	$7,399	$7,395
13	Manchester Memorial Hospital	$5,804	$5,775	$6,460
14	Middlesex Hospital	$7,976	$8,616	$8,208
15	MidState Medical Center	$7,483	$7,764	$7,651
16	Milford Hospital	$7,530	$7,115	$8,647
17	New Milford Hospital	$7,951	$8,306	$9,229
18	Norwalk Hospital	$10,678	$10,258	$10,397
19	Rockville General Hospital	$6,045	$6,837	$6,944
20	Saint Francis Hospital and Medical Center	$7,109	$7,617	$7,780
21	Saint Mary's Hospital	$5,651	$5,791	$5,712
22	St. Vincent's Medical Center	$8,512	$8,334	$8,568
23	The Charlotte Hungerford Hospital	$5,799	$5,700	$5,677
24	The Hospital of Central Connecticut	$8,307	$8,019	$8,108
25	The Stamford Hospital	$10,274	$9,417	$9,279
26	The William W. Backus Hospital	$6,519	$6,293	$6,632
27	Waterbury Hospital	$7,845	$8,652	$8,419
28	Windham Community Memorial Hospital	$6,145	$6,165	$5,681
29	Yale-New Haven Hospital	$11,211	$11,497	$11,546
30	Connecticut Acute Care Hospitals Weighted Average	$8,760	$9,190	$9,094

	FY 2010	FY 2011	FY 2012
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.

W

Chad W. Wable, MS, MBA, FACHE

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Redacted (home) • Redacted (cell) • Redacted

PROFESSIONAL STATEMENT

A PASSIONATE, CONTEMPORARY AND HIGHLY ACCOUNTABLE LEADER DEDICATED TO BUILDING ESSENTIAL RELATIONSHIPS WITHIN THE MEDICAL COMMUNITY AND BROADER COMMUNITY IN ORDER TO COME TOGETHER AS A TEAM TO TRANSFORM HEALTHCARE INTO A CONSUMER-ORIENTED SYSTEM OF REGIONAL HEALTHCARE SERVICES WITH THE RIGHT PATIENT RECEIVING THE RIGHT CARE IN THE RIGHT LOCATION RESULTING IN A VERY GOOD PATIENT EXPERIENCE THAT IS SUBSTANTIALLY BETTER QUALITY CARE, TRUSTED AND SAFE WHILE DRAMATICALLY REDUCING THE TOTAL COST OF CARE OVER TIME.

EXPERIENCE

Saint Mary's Health System, Inc., Waterbury, CT

Integrated network of healthcare services including Saint Mary's Hospital (347 beds), a Level 2 Trauma Center and NICU, Saint Mary's Hospital Foundation, Saint Mary's Indemnity Company, Naugatuck Valley Surgical Center, Harold Leever Regional Cancer Center, Heart Center of Greater Waterbury, Diagnostic Radiology of Southbury, Naugatuck Valley MRI, and Franklin Medical Group.
STATS: 12,000 admissions, 70,000 ED visits, 18,000 surgeries, 3 residency/teaching programs, $280 million in net revenues, 400 active members of the medical staff and 2,000 staff.

<u>President and Chief Executive Officer (2008-present)</u>

Major Accomplishments:

Growth and Finance

- ✓ One of seven hospitals in CT to achieve a positive five-year average operating margin.
- ✓ Increased DCOH from less than10 days to over 70 days.
- ✓ Lowest cost hospital in CT based on total cost per discharge.
- ✓ Established largest robotic surgery program in the region.
- ✓ Operate the largest freestanding surgical center in CT.
- ✓ Opened first community hospital based open heart and angioplasty program in CT.
- ✓ Aligned three physician groups into one large, integrated 100 provider multi-specialty group.
- ✓ Consolidated pediatric services in Waterbury with Connecticut Children's Medical Center establishing a hospital within a hospital at Saint Mary's Hospital.
- ✓ Established a hospital within a hospital partnership with VITAS for an inpatient hospice.
- ✓ Led the Board through an affiliation process resulting in multiple options for a transaction.
- ✓ Led the establishment of a wholly owned insurance company and risk management program.

Service and Quality

- ✓ Received the national quality performance award by the Joint Commission.
- ✓ One of Ten hospitals nationally selected to receive an ACC Patient Navigator Program Grant.
- ✓ Improved inpatient and ambulatory surgery HCAHPS more than 50 percentile points.
- ✓ Reduced patient falls and hospital acquired infection from over 200 to less than 100.
- ✓ Achieved top decile nationally for over 77% of all reportable CMS Core Measures.
- ✓ Achieved recognition five consecutive years by AHA *Get with the Guidelines* as a Gold Award Hospital for treatment of heart failure, MI and stroke.
- ✓ Achieved Consumer Reports safest hospital in CT 2013 and 2014.
- ✓ Recognized as a Top 100 Community Value Leadership Award Winner by Cleverley and Assoc.

<u>Executive Vice President, Strategy Development and System Operations (2008)</u>

<u>Vice President of Ambulatory Operations and Business Development (2003-2008)</u>

Responsible for strategic management, business development and community relations activities for the Health System. Responsible for all outpatient operations within the Health System with responsibility for growing market share, achieving Balanced Scorecard results and leading change within the organization.

Major Accomplishments:

- ✓ Served as a member of the senior management team responsible for successfully implementing a $24M financial turnaround plan.
- ✓ Led the planning, development and CON process for the establishment of a collaborative open heart and cardiac angioplasty program.
- ✓ Successfully recruited several physicians including several internists, breast surgeons, neurosurgeon, neurologist, cardiologists and a cardiothoracic surgical team.
- ✓ Led the development of a new Stroke Program consistent with the American Stroke Association *Get with the Guidelines* program.
- ✓ Led the development of a Bariatric Surgical Program in pursuit of accommodation as a Center of Excellence by the ASMBS and SRC.
- ✓ Established comprehensive community benefits program.
- ✓ Led the development of a comprehensive women's & breast services strategy including a new breast surgical practice and the development of diagnostic services.
- ✓ Led redesign of ambulatory care delivery system including six new outpatient facilities and enhanced technology resulting in over $1.0 million in annual incremental income.
- ✓ Introduced new patient advocacy program including patient rounding, real-time recovery process and a functional reporting system.
- ✓ Led team responsible for coordinating and developing an affiliation strategy including assessing local consolidation and national partnership options.
- ✓ Led the redesign of a primary care network of hospital sponsored and private practices.
- ✓ Led the establishment of the first freestanding hospital-owned MRI Center in Waterbury.

<u>Corporate Director of Strategic Planning and Business Development (2002-2003)</u>

Responsible for leading the Board and Senior Management through a comprehensive strategic planning process resulting in the first system-wide long range strategic plan including master facility, medical staff development, quality improvement, image improvement, information systems and long range financial plans. Provided management support for marketing, community relations, medical staff development, imaging services, health information management, plant operations and support services. Reported directly to President & CEO.

Major Accomplishments:

- ✓ Lead annual strategic planning process including annual update of a five year strategic plan.
- ✓ Designed and administered a Balanced Scorecard for enhancing relationships, clinical effectiveness and improving operating performance.
- ✓ Led the completion of a comprehensive master facility plan including optimizing the current facility and long term options for rebuilding in place and new construction.
- ✓ Led the completion of the medical staff development plan including a community needs assessment, physician satisfaction survey and the establishment of physician recruiting policies, procedures and strategies.
- ✓ Designed and implemented an image improvement strategy including the redesign of the marketing and community relations functions resulting in dramatically improved brand identity and consumer perception.
- ✓ Led redesign of imaging services including establishment of a new professional services agreement with a local radiology group.
- ✓ Led team responsible for improved charge capture and front-end revenue cycle improvement.

Monongalia Health System, Inc., Morgantown, WV

Integrated network of healthcare services including Mon General Hospital, The Foundation of Mon General Hospital, MonHealthcare Equipment & Supplies, Monongalia EMS, The Village at Heritage Point, Healthworks Rehab & Fitness, Care Partners, HealthSouth Rehab Hospital.

<u>Director of Strategic Planning and Business Development (2000-2002)</u>

<u>Strategic Analyst (1999-2000)</u>

Post-graduate Fellowship, Healthcare Administration (1999)

West Virginia University, Morgantown, WV

Instructor, Community Health Education (1998-1999)

EDUCATION

West Virginia University, Morgantown, WV
Master of Business Administration, August 2002
Master of Science in Community Health Education, December 1999
Master Certificate in Healthcare Administration, December 1999
Bachelor of Science in Biology, May 1998

PROFESSIONAL AFFILIATIONS/CERTIFICATIONS

American College of Healthcare Executives – Fellow
American Hospital Association, Metropolitan Governing Board
Connecticut Hospital Association – Board of Directors
CT Chapter American College of Healthcare Executives – Board of Directors
Certified High Reliability Trainer through HPI
Six Sigma Green Belt with Lean and Workout Training through Juran Institute

COMMUNITY SERVICE

United Way of Greater Waterbury, Board of Directors, Chairman (2010-2012)
Greater Waterbury YMCA, Board of Directors
Waterbury Regional Chamber of Commerce, Board of Directors
Saint Bridget's School, Board of Directors
Rezziliant, Inc., Board of Advisors (2005-2010)
Visiting Nursing Association, Board of Directors (2004-2007)

AWARDS AND HONORS

Connecticut Magazine 40 under 40 Award recipient (2011)
Modern Healthcare Magazine "Up & Comers" Award recipient (2010)
American College of Healthcare Executives, Early Careerist Award, Connecticut Chapter (2006)
West Virginia University, Varsity Football

- Big-East Conference Scholar-Athlete first team (1994-1997)
- Ira E. Rogers Award for high leadership, academic qualities, and football performance (1997)

Joseph Connolly Redacted Redacted Home: Redacted Cell: Redacted

Overview

A dynamic, creative marketing professional with diverse experience and a 20-year track record of success. Strong strategic and innovative thinking abilities. An exceptional communicator with the ability to address multiple constituencies using all media. A proven top-level performer in entrepreneurial, organizational, and academic settings.

Specific skills and areas of expertise

- Marketing strategic planning
- Communications campaign development
- Strategic brand development and management
- Community & media relations
- Philanthropy and development
- Emergency preparedness & crisis communications
- Presentations/Public speaking
- Meeting facilitation/brainstorming
- Creative Concept development & implementation
- Large scale project management

Professional Experience

Vice President, Community Affairs and Chief Marketing Officer
Saint Mary's Hospital 2003-present

Responsible for the creation and implementation of a comprehensive marketing and communications plan that has positioned Saint Mary's among the fastest growing hospitals in Connecticut and resulted in a 10% gain in market share. Communicate effectively with a broad base of audiences and constituencies, including hospital staff, physicians, local business leaders, legislators, government officials, and the community.

General areas of responsibility include:

Strategic Planning: Responsible for the development of the overall strategic marketing plan for Saint Mary's Health System, which consists of more than ten separate facilities, including Saint Mary's Hospital, three community Health and Wellness Centers, two Sleep Disorders Laboratories, and a Wound Healing Center.

Marketing: Develop overall marketing strategy, including customer research, development of key messages, brand development, on-line and traditional media plans, and comprehensive integrated communication campaigns. Extensive focus on web site performance, social media and digital marketing. Utilize web analytics to inform content creation and web structures. Work with other administrators and service leaders to enhance the overall customer experience.

Publication Development: Provide overall leadership, editorial support and creative direction for three major publications with a combined circulation of more than 200,000. Supervise a team of writers, designers, and photographers who together produce 21 separate issues annually.

Emergency Preparedness and Crisis Communications: Act as Public Information Officer for all crisis situations. Develop communications for all hospital crises including natural disasters and large scale community incidents. Ongoing training and development for potential incidents such as mass shootings, or large scale health risks; completed Federal Incident Command Center training.

CEO Communications: Work closely with CEO for all communications needs, including presentations, weekly CEO message, letters and correspondence.

Government Relations: Prepare and implement hospital's legislative agenda. Develop working relationships with Federal and State legislative delegation and elected officials. Coordinate activities with industry

associations and other special interest groups. Represent hospital in Washington and at Connecticut General Assembly.

Philanthropy and Organizational Development: Direct responsibility for the Saint Mary's Foundation. Work closely with Board of Directors and Foundations Staff to develop overall strategy and plan.

Service line Support: Work with individual service line leaders to brainstorm, create and implement multi-faceted marketing programs to achieve specific performance objectives. Campaigns typically include print advertising, direct mail, and internet components.

Media Relations: Responsible for creating media plans and strategies. Regularly act as media spokesperson for newspaper, radio and TV. Develop specific action plans and strategies for crisis communications. Identify appropriate hospital representatives on a case-by-case basis in response to media inquiries. Provide media coaching and support for hospital leadership and management.

Special Events: Provide extensive marketing support for all hospital and Foundation special events such as annual gala, golf tournament, employee award & recognition event, annual meeting and leadership retreats.

Founder & President **Aro Strategic Marketing** **2000-present**

Led entrepreneurial company focused on providing strategic marketing services to diversified clients including companies in the high-tech, banking, manufacturing, professional services, start-up and non-profit sectors. Managed successful, results-driven senior-level relationships with all clients.

- Produced comprehensive marketing campaigns (using print, broadcast, and digital media) from concept through completion
- Helped clients achieve specific marketing goals related to market awareness, revenue generation, and growth
- Created roster of strategic partners throughout North America providing related services such as printing, video production, photography, and web development
- Presented various marketing programs to professional and business organizations
- Wrote regular marketing column in the CT Tech Tribune

Founder, President & Creative Director **Connolly & Connolly, Inc.** **1990-2000**

Launched a full-service marketing communications company in 1990 and grew it to fee-based revenues of $1.5 million annually. Provided day-to-day leadership and management for an in-house team of communications professionals including graphic designers, computer specialists, account managers, and administrative staff.

- Developed effective, reproducible processes for combining strategic planning with creative development to achieve client goals and objectives
- Coordinated domestic client work with international offices throughout the world, including Asia, Europe and South America
- Presented strategies and concepts to clients to achieve buy-in and approval for implementation
- Served as two-term president of the Connecticut Art Directors Club

Adjunct Professor **University of Connecticut** **2007-present**

Taught graduate and undergraduate level marketing courses at the university's Hartford and Waterbury campuses.

- Integrated Marketing Communications (MKTG 362)
- Services Marketing (MKTG 314)
- Received student rankings of 9.5

Community involvement

- Current community activities:
  - United Way of Greater Waterbury, Board of Directors
  - Saint Vincent DePaul, Board of Directors
- Previously held roles:
  - Vice President, Saint John of the Cross Parish Council
  - Chairman, Board of Directors, Waterbury Health Council (Greater Waterbury Regional Chamber)
  - Vice-Chairman, Board of Directors, Child Guidance Clinic of Greater Waterbury
  - Board of Directors, Naugatuck Economic Development Corporation

Education

- MBA, University of Connecticut
- Strategic Brand Development. Dartmouth College, Tuck School of Business
- BS in Mass Communication, Boston University

Personal interests

- IronMan Triathlon: Four-time IronMan finisher
- Sports: Playing them, watching them, reading about them, talking about them
- The Arts: Photography, music, film, theater
- Reading: Anything I can get my hands on

Happily married, with three outstanding teenage daughters

Ralph W. Becker

Experience:

Saint Mary's Health System, Inc., Waterbury, Connecticut
Vice President of Finance and CFO — January 2014 - Present

Midstate Medical Center (subsequently part of Hartford Healthcare System)
Vice President of Finance and CFO — 1985 - 2014

Ernst & Whinney (now Ernst & Young)
Health Care consultant in Connecticut — 1981 – 1985

Blue Cross and Blue Shield of Connecticut (now Anthem/ Wellpoint)
Audit and Reimbursement Analyst (progressing to supervisor) — 1974 – 1981

Education:

Norwich University (Vermont)
BS in Business Administration

University of New Haven
Master of Business Administration in Finance

Michael A. Novak, MSM, MBA, FACHE

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Summary of Qualifications

Dedicated senior management executive with proven expertise in hospital operations, high reliability, leadership development, physician relationships and ambulatory operations management, quality and service excellence, with strong interpersonal and communication skills. Broad competencies in the following organizational responsibilities:

Hospital Ambulatory Operations	**Physician Practice Operations**	**Service Line Development**
Service and Quality Excellence	**Strategic Planning**	**High Reliability Development**
Operational Improvement	**Six Sigma Green Belt**	**Information Technology**

- Over twenty years of progressive, senior-level healthcare management experience with skills in reengineering and restructuring hospital operations and outpatient service lines operations to improve reliability and reduce variation.
- Establishment of a cardiac service line utilizing a dyad management structure to drive service and quality, manage costs and improve profitability.
- Strong strategic and business planning skills that include the successful implementation of numerous new ambulatory and physician-led services and programs within a highly competitive market.
- Extensive physician relationship building background combined with the proven ability to manage a hospital with senior level experience in all major hospital departments
- Demonstrated ability to lead high reliability development and utilize Lean method analyses to improve strategic performance improvement and quality initiatives
- Broad knowledge in contract administration with in-depth experience in contract language review, real estate leasing, revenue modeling, organization development, cost control, team building and project implementation. Harvard Law School training course in negotiation skills and tactics
- Successful employee satisfaction and engagement capability ranking as the highest senior leader in overall employee satisfaction for two consecutive years. Strong team-building skills
- Astute problem solver with strong IT skills who applies financial and analytical expertise in profit and loss management and hospital business planning analysis to achieve performance objectives.
- Strong familiarity with regulatory requirements and emerging healthcare trends.
- ACHE Student Mentor for early careerists
- AAAHC life safety surveyor (in training)

Work Experience

Saint Mary's Hospital – ***Waterbury, Connecticut***
SMH employs 1238 FTEs with 179 staffed beds, licensed for 341 beds. SMH is a teaching facility with residency programs internal medicine, surgery and dentistry. In FY13 SMH reported 26,407 adjusted discharges and 51,555 patient days resulting in total operating revenue of $275 Million, expenses of $265 Million, resulting in a margin of $11 Million or 4%.

2008-Present - *Vice President of Operations and Ancillary Services- Saint Mary's Health System (SMHS)*
Accountable for the direct control of net revenues in excess of $100M, responsible for 385 FTES, and reporting directly to the Saint Mary's Hospital CEO, the VP for Operations and Ancillary Care functions as a senior operating officer within the system and is accountable for the performance of the cardiac service line, including the associated critical care nursing units, radiology, pharmacy, laboratory, facility operations, environmental services, food services, communications, biomedical engineering, security, emergency preparedness, managed care, walk-in centers and other ambulatory services for all SMHS entities.

- Lead an average of 8.2% outpatient net revenue growth over the past four years, (7.2% in FY10, 6.5% in 2011, 11.3% 2012, 7.7% 2013) through the development of detailed growth campaigns in each major area of responsibility.
- Achieved staff productivity of 100% of target for FY13 and budget compliance of 100.2%.
- Developed a cardiac service line to lead 4% growth utilizing a dyad management structure to drive service and quality, manage costs and improve profitability. (2014)
- Lead a monetization plan to commission the creation of an adjacent professional office building to be leased back to the hospital to minimize capital outlay. (2014)
- Developed a radiology outpatient imaging strategy to acquire the facilities of the local radiological group and outlined the business strategy for the onsite MRI dissolution (2014)
- Created a refined seven year Master Facility Planning process to outline the future growth and infrastructure needs for the Health System including a $73M infrastructure replacement and new construction schedule to help balance capital needs (2013)
- IT liaison to develop the outsourcing of Saint Mary's IT to Anthelio, St. Louis, MO. Developed contractual arrangements, service level criteria and guide the transition of leadership to the new firm (2013)
- Lead the $1.7M major redesign and renovation to the patient access, registration and one stop testing area creating a totally new patient reception area with enhanced patient flows, reduced wait times and greatly improved patient and staff satisfaction. (2012)
- Constructed and implemented a new and second Cardiac Catheterization Lab utilizing state-of-the-art *Siemens Artis Zee* equipment including the creation of a new vascular service line. (2012)
- Developed Connecticut's only new inpatient hospice unit in the last ten years. Working with VITAS, designed and renovated old hospital office space into an impressive twelve bed inpatient hospice unit. Developed contracting and operating agreements to govern the new affiliation (2011)
- Upgraded all cardiac echocardiography, radiological systems and departmental PACs systems resulting in a totally digital imaging department (2011)

- Successfully upgraded the Hospital's CT capacity installing two new Phillips CT systems, a 64 slice and 16 slice units. Restructured the departmental configuration for the new units to improve workflow, increase reliability and reduce variation in the speed of patient testing (2011)
- Revised the Hospital's capital purchasing budgeting process to provide a more streamlined and comprehensive approach to strategizing capital allocations (2011)
- Serve a project leader for the successful implementation of a joint-hospital inpatient pediatric program in conjunction with Connecticut Children's Medical Center (2011)
- Implemented a contract oversight system that tracks all hospital contracts for compliance to terms as well as providing on line access to approved individuals (2009)

2004-2008 - Vice President of Professional Clinic Operations, and Graduate Medical Education
Functioned in dual-roles as Vice President for Professional Operations for Saint Mary's Hospital and Executive Director of the Health System's Faculty Practice – Franklin Medical Group, PC

Reporting directly to the Saint Mary's Hospital CEO, was responsible for all aspects of operations for the health system's professional medical practices, numerous hospital departments, and graduate medical education programs including affiliation with the Yale School of Medicine. Responsibilities included the strategic development of the health system's multi-million dollar faculty practice including affiliate management, medical staff development, payer contracting, new program development, revenue enhancement and community physician relations. Physician strategies included the development of physician programs and practices to ensure future hospital coverage in areas of demonstrated community need.

- Successful administration and accreditation of the Medical, Surgical, Dental and Institutional Graduate Medical Education Programs at Saint Mary's Hospital and a Medicine/Pediatrics program in affiliation with Yale School of Medicine (2008)
- Refinement of ambulatory care programs and clinics to minimize loss, dramatically improve productivity, yet preserve the commitment to the hospital's charitable mission (2008)
- Implementation of a contract management recovery program yielding in excess of $600,000 in contractual recoveries for each of the last three years (2008)
- Recruitment of three new surgeons to expand hospital teaching capabilities and improve surgical volumes. (2007)
- Restructured the Health System's Utilization Management Department achieving a first year reduction in average Length of Stay of (.8 days) (2008)
- Actively directed three for-profit affiliate organizations employing over 205 FTE's with highly detailed business-unit budgets demonstrating associated productivity targets, physician incentives, revenue projections and strategic initiative progress reporting (2005)

2004-2008 - Executive Director - Franklin Medical Group, PC (FMG)

Reporting in a dyad management structure with the faculty practice President to the faculty practice Chairman of the Board. Focused on enhancing all provider operations and promoting business development for Saint Mary's largest wholly owned affiliate, Franklin Medical Group, PC.

- Developed internal and external business initiatives for physician business lines, productivity and performance enhancement tracking, long-term relationship initiatives, long-

range planning, cost efficiency, compensation incentives, balanced scorecard reporting, and quality initiatives

- Implemented the complete transition of all providers from a hospital-employed model into a faculty practice model with unified incentive plans allowing for improved reimbursement and revenue enhancement, boosting FMG revenue by 235%
- Developed a detailed budget system separating physician operations by cost center including the capability for individual physician productivity monitoring .

2001-2004 - Division Director – Ambulatory and Professional Clinic Operations

Reporting directly to the Saint Mary's Hospital Senior Vice President, was responsible for all aspects of the health system's Cardiology, Pulmonary, Physical Therapy and Neurology departments, as well as Managed Care negotiations, the Health System's PHO, offsite ambulatory/walk-in centers and strategic joint ventures.

- Implemented the complete digitization of the Echocardiography Laboratory reducing the delay for cardiac ultrasound results from four days to same day on average
- Implemented the conversion of the neurology EEG laboratory from a pen-based analog system to digitized images including the ability to store images on CD for offsite neurologist review

2001-2001 - (Special assignment) Interim Executive Director

Assumed as the interim Executive Director of Harold Leever Regional Cancer Center. The joint-hospital cancer center development project became entangled in a number of operational and managerial issues. Was asked to assume control as see the project to completion. Led the revitalization of middle management and re-established the on-time and on-budget development of the $17 million regional cancer center initiative. Successfully reintegrated physician and community partners. Negotiated contracts for the provision of equipment in excess of $4.6 million.

1998-2001 – PHO Director – Physician Networks

Reporting directly to the Saint Mary's Hospital Executive Vice President, was responsible for continued development of the health system's Managed Services Organization (MSO) including the development of a primary care network, managed care contracting, Physician-Hospital Organization (PHO), off site property management, and strategic joint ventures. Developed the MSO to provide service for 19 physician groups including 39 employed physician providers as well as managed risk plan data for over 300 PHO community participants. Led the deployment and development of a 17 MD, nine site, primary care network (Scovill Medical Group) that provides in excess of 15% of the hospital's PCP admissions through today.

1996-1998 - Director of Information Technology and Operations

A subsidiary of Saint Mary's Hospital, the Central Connecticut Physician Practice Management Organization, LLC (CCPPMO) was a startup MSO. Reporting directly to the Health Systems Executive Vice President and employed since startup, was responsible for the management and direction of all operations aspects of the health system's Managed Services Organization (CCPPMO).

Waterbury Hospital, Waterbury, CT

Waterbury Hospital employs 1512 FTEs with 190 staffed beds, licensed for 284 beds. Waterbury Hospital is a teaching facility with residency programs in primary care and surgery. In FY11 Waterbury Hospital reported 12,758 discharges, a total operating

revenue of $236 Million and expenses of $236 Million resulting in a margin of $674,487 or 0.29%.

1989-1996 - Director of the Information Center, Computer Operations and Technical Support

Responsible for the complete administration, budgeting, personnel and development of the Information Center. Directly managed a 7 X 24 hour computer operation including areas of hospital-wide technical support, disaster recovery and computer operations.

Saint Mary's Hospital - *Waterbury, CT*

1986-1989- Programmer Analyst II

Responsible for the implementation of new IT systems and physician office system technology. Reported to the Director of Information Services and was primarily responsible for the installation, support and development of physician office billing systems and physician network development eventually deployed to 47 sites and 101 physicians

1985-1986 - Pulmonary Technologist/Computer Programmer

Assigned to the pulmonary division, provided pulmonary testing to both inpatients and outpatients. This position was additionally responsible for new computerization development and research within the pulmonary/respiratory area.

Education

Albertus Magnus College – New Haven, Connecticut

- *Master of Business Administration with Honors*
- *Master of Science in Management with Honors*

Boston University – Boston, Massachusetts

- *Bachelor of Science, Biology*

Juran Institute, Southbury, Connecticut

- Six Sigma Green Belt

Accreditation Association for Ambulatory Health Care (AAAHC)

- Life safety surveyor (in training)

Memberships and Positions Held

Board of Directors – Connecticut Hospital Association, Diversified Network Services
Board of Directors – Connecticut Chapter of ACHE
Board of Directors – City of Waterbury Development Corporation
Board of Directors – Harold Leever Cancer Center
Board of Directors – Heart Center of Greater Waterbury
Board of Directors – Diagnostic Imaging of Southbury
Board of Directors – Franklin Medical Group, PC

Fellow – American College of Healthcare

Chairman, Town of Woodbury Zoning Board of Appeals
Co-Chairman, CTACHE Membership Committee
Member – Medical Group Management Association

Member – Hospital Financial Management Association
Member - Kappa Gamma Pi, National Graduate Honor Society
Monthly Volunteer – local Waterbury soup kitchen

Personal Information

Married with two boys ages 16 and 11
Hobbies: Skiing, golfing, woodworking

References

Provided Upon Request

JAMES B. TUCKER

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PROFILE:
Accomplished healthcare quality and patient safety leader with many years experience in clinical quality, performance improvement, infection prevention and control, regulatory compliance, and statistical analyses. Strengths include team facilitation, communication, creative problem solving, service orientation, and aligning the strength of teams to achieve success. Written, published, and presented on a variety of topics. Received multiple awards and recognitions in quality.

PROFESSIONAL EXPERIENCE

SAINT MARY'S HOSPITAL, Waterbury Connecticut 2004-Present
Saint Mary's is an acute care hospital licensed for 347 beds offering inpatient medical-surgical and intensive care services. It provides comprehensive/advanced cardiac services and is a Level II trauma center with a high volume emergency department offering numerous inpatient and outpatient services. The hospital serves the inner city population of Waterbury and its surrounding communities.

Vice President Mission Integration and Chief Quality Officer 2013 – Present
Promoted into the first mission leadership position at Saint Mary's Hospital. Responsible for Quality Management, Infection Prevention, Risk Management, Corporate Compliance, Pastoral Care, Regulatory Affairs, Medical Staff Office, and Library Services. Chair the Ethics Committee and serve on the Clinical Ethics Consultation Team. Serve on various committees. Recent organizational accomplishments include:

- Attained the highest CMS value-based purchasing increase among all hospitals in the State for the 2014 adjustment period.
- Proposed and launched high reliability program for all staff and medical staff to improve predominantly safety but also quality and service. One third of staff trained to date.
- Improved overall core measures performance to 96.5%.
- HCAHPS patient satisfaction scores have shown steady improvement over the course of the current fiscal year.
- Underwent the most successful Joint Commission accreditation visit in organizational history (fewest number of findings) in April 2014.

Division Director of Clinical Quality 2004-2013
Responsible for leading and overseeing all performance improvement activities for the organization. Responsible for regulatory compliance, infection prevention, patient safety, and pay-for-performance. Help set the agenda and regularly report to the Quality Committee of the Board. Activities and improvements included the following:

- Improved heart attack core measures composite scores from 75.1% to 100%. Improved heart failure core measures composite score from 90% to 100%. Achieved top decile performance among more core measure indicators than 90% of the hospitals in Connecticut.
- Cardiac Quality Team applied for and received recognition for performance in coronary artery disease (CAD) and heart failure (HF) care. Received Gold Award in 2009 and 2010 from American Heart Association's Get With The Guidelines (GWTG) program for two years of sustained performance in

caring for patients with CAD and the Gold Award in 2010 for two years of sustained performance in caring for patients with HF.

- Quality team developed and implemented comprehensive stroke program successfully attaining state designation as a primary stroke center in 2008. Received the Silver Award in 2011 and the Gold Award in 2012 for Stroke performance from GWTG and the American Stroke Association.
- Have led the hospital in reducing patient harm through various initiatives including reduction of hospital-acquired infections by 56% from 2009 to 2012. Virtually eliminated central line-associated blood stream infections (to median rate of zero) and ventilator-associated pneumonias (12 months without a single event) in critical care and greatly reduced the number of catheter-associated urinary tract infections. Received Connecticut Quality Improvement Award for Innovation in 2007 for program to reduce hospital-acquired urinary tract infections. Reduced the number of patient falls by more than 50%. As a result of some of this work, in 2013 Consumer Reports ranked Saint Mary's Hospital as having the fifth highest patient safety rating among teaching hospitals in the country.
- Proposed and implemented American College of Surgeon's National Surgical Quality Improvement Program identifying and implementing opportunities for improvement. In 2013 targeting surgical site infection rate reduction by 50%.
- Lead the organization's participation in Anthem's pay-for-performance program (Q-HIP) yielding more than $750,000 in additional revenue in the first two years of the program.
- Received the hospital's Team Excellence Award in 2008 for implementing interdisciplinary clinical quality rounds improving performance in key quality measures. Was nominated for the hospital's Archbishop Award for Integrity in 2012.
- Support cardiac quality activities for the invasive cardiology program through use of the American College of Cardiology's Cath-PCI registry (ACC) and the Society for Thoracic Surgeon's comparative database. Time to PCI has reached the top decile percentile compared to the ACC database.
- Established a continual regulatory readiness strategy. Completed successful surveys for the Joint Commission accreditation visits in 2005, 2008, and 2011 and the Connecticut Department of Public Health licensure visit in 2010 and 2012.

STAMFORD HEALTH SYSTEM, Stamford Connecticut 1993-2004

The health system is comprised of a 305-bed acute care teaching hospital designated as a Level II Trauma Center, an inpatient psychiatric unit, an acute rehabilitation unit, an extended care facility, a continuing care retirement community, a visiting nurse, and a hospice residence.

Director of Clinical Effectiveness 2003-2004

Responsible for the progress and oversight of all clinical performance improvement initiatives across the organization. Facilitated interdisciplinary performance improvement teams in partnership with medical staff, nursing, and case management. Served as staff to the Board Quality and Clinical Affairs Committee and the Clinical Leadership Council.

- Redesigned reporting requirements for all departments reporting to the central quality committee to foster communication, accountability, and alignment with the strategic plan.
- Developed organizational quality scorecard tracking performance across multiple care areas, identifying reasons for variation, and communicating action plans for improvement.
- Developed and disseminated physician performance reports to the entire active medical staff for credentialing purposes and to establish a feedback mechanism with the medical staff.
- Clinical effectiveness team improvements included: increasing reimbursement for spinal surgery patients by correcting billing codes, reducing LOS of patients on ventilators, reduced LOS of COPD

patients from a baseline average of 5.2 days to 4.1 days, reduced LOS of stroke patients from an FY 03 average of 7.8 days to 5.8 days.

Internal Consultant/Project Manager 2000-2003

Served as consultant on internal project team. Managed multiple clinical and organizational improvement projects focusing on improving patient care, operations, and expense reduction.

- Developed DRG priority index based on volume, cost, and length-of-stay. Set agenda for performance improvement through the use of national and state benchmark performance comparisons.
- Developed evidenced-based guidelines and care paths for multiple patient populations. Ensured guidelines of care for patients with high volume DRGs were consistent with the latest medical evidence.
- Reduced variation in care of patients undergoing total joint replacement resulting in shorter lengths-of-stay while improving quality measures.
- DRG initiatives reduced expenses by $1.5 million per year and pharmacy initiatives achieved annual savings of $100,000.
- Developed severity adjusted physician utilization reports. Generated cost and length-of-stay reports for each physician specialty.
- Implemented a system-wide executive scorecard/ performance measurement and monitoring system creating framework for development of departmental scorecards.

Trauma Program Manager/Administrative Coordinator-Department of Surgery 1993-2001

Managed all aspects of the trauma program that qualified Stamford Hospital as a verified/ designated Level II Trauma Center. Managed program overseeing care of severely injured patients from pre-hospital to emergency department, operating room, and critical care to discharge. Reviewed performance of all aspects of care for this patient population. Coordinated the Columbia University affiliated surgical residency program.

DANBURY HOSPITAL, Danbury, Connecticut 1990-1993

Danbury Hospital is a 371-bed not-for-profit community teaching hospital offering comprehensive acute care services. It contains one of the busiest emergency departments in the state of Connecticut.

Assistant Nurse Manager Emergency Department

Managed clinical staff responsible for evening patient care in the emergency department with a volume of over 55,000 patient visits per year.

THE STAMFORD HOSPITAL, Stamford, Connecticut 1985-1990

Nurse Manager Oncology Unit

Provided patient care to acute oncology patients undergoing surgery, radiation, and chemotherapy. Provided respite care for hospice patients and end-of-life care to dying patients. Managed all aspects of patient care delivery, budgeting, staff scheduling, quality, and interdepartmental issues.

HÔPITAL BEMBERÉKÉ, Benin, West Africa 1984

A small sub-saharan hospital run by Sudan Interior Mission. Managed the pharmacy and provided clinical care to patients being served by the hospital.

EDUCATION

Six Sigma Black Belt Training, Juran Institute, Southbury, Connecticut 2007
Management Fellow, Advisory Board Academy Fellowship Program, Washington, D.C. 2003-2005
M.B.A. Information Systems and Management, Stern School of Business, New York, New York 1997
B.S. Nursing, Vanderbilt University, Nashville, Tennessee 1984

LICENSE/CERTIFICATIONS

Connecticut Registered Nurse: E47582
Certified High Reliability Trainer

COMMUNITY SERVICE

Board of Directors, Christian Heritage School (Chairman from 2008-2013)	2005-2014
Mission Trips to Haiti and India	2010-2012
Member, Board of Directors, Stamford Hospital Employees Credit Union	2002-2004

PUBLICATIONS

Parry MF, Wright PW, Stewart J, McLeod GX, **Tucker J**, Weinberg AR. Impact of an Adherence Program on the Health and Outlook of HIV-Infected Patients Failing Antiretroviral Therapy. *J Int Assoc Physicians AIDS Care* 2005;4(3):59-65.

Barone JE, **Tucker JB**, Perez JM, Odom SR. Ghevariya V. Evidence-based medicine applied to sentinel lymph node biopsy in patients with breast cancer. *American Surgeon* 2005;71(1):66-70.

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Tucker JB, Stewart J, Barone JE, Hogan RJ, Sarnelle JA, Blackwood MM. Violence prevention: Reaching adolescents with the message. *Ped Emerg Care,* 1999; Dec;15(6):436-9.

Aronis M, Corvo P, Barone JE, Salib J, **Tucker JB,** Rha CK. Preoperative pulmonary artery catheterization has no impact on outcome. *Contemp Surg*, 1998;53:25-9.

PRESENTATIONS

Tucker JB, Cordeau P. Evaluating and Monitoring: Falls Prevention Program. Presented at Connecticut Hospital Association Falls Collaborative Meeting April, 2011.

Tucker JB. Change Acceleration Methods. Presented at the New York Presbyterian Health System Summer Symposium Best Practices in Quality and Patient Safety, New York, July 2004.

Tucker JB, Harlin T. Leapfrog, Technology, and the Balanced Scorecard. Society for Healthcare Strategy and Market Development, Dallas, TX, September 2003.

Tucker JB, Barone, JE. Improving the accuracy and efficiency of the surgical operative log. Presented at Association of Program Directors in Surgery, Nashville, TN, March, 2001.

Conway C, **Tucker JB**, Barone JE, Savetamal A, Smego DR. Local car seat safety inspections: Comparison to national data. Poster presentation at American Association for the Surgery of Trauma, San Antonio, TX, October 2000.

Tucker J, Brown A, Barone J, Blabey R, Thomas M. "Hot zone" identification: The value of road crash data analysis. Annual Meeting, Connecticut Chapter, American College of Surgeons, Cromwell, CT, November, 1999.

Tucker JB, Guglielmo E, Yung C. The culture of quality at The Stamford Hospital. Stern School of Business, New York, NY, December, 1998.

Rodriguez C, Barone JE, **Tucker JB**, Masino FA, Dowling SW, Isidor J, Masino H, Blabey RG Jr. Conservative surgery and radiation for breast cancer: Long term outcomes. Annual Meeting, Connecticut Chapter, American College of Surgeons, Cromwell, CT, December, 1998.

Tucker JB, Barone JE, Cecere J, Blabey, RG, Rha C-K. Using Queueing theory to determine operating room staffing needs. American Association for the Surgery of Trauma, Baltimore, MD, September, 1998. Annual Meeting, Connecticut Chapter, American College of Surgeons, Cromwell, CT, December, 1997.

Shames D, **Tucker JB**, Gardner P. Serum amylase, lipase and the lipase/amylase ratio in the prediction of the severity of acute pancreatitis. Connecticut Medical Association annual resident competition, Hamden, CT, May, 1997.

Tucker JB, Stewart J, Barone JE, Hogan RJ, Sarnelle JA, Blackwood MM. Violence prevention: Communicating with adolescents. Presentation to the Eastern Association for the Surgery of Trauma, Sanibel, Florida, January, 1997.

Tucker JB, Reinhard E, Barone JE, Smego D. Analysis of efficiency in a trauma response system. Annual Meeting, Connecticut Chapter, American College of Surgeons, Cromwell, CT, December, 1996.

Tucker JB. Measurement and Management in Trauma Care. Presentation as invited guest speaker at the Columbia University Seminars, New York, March, 1996.

Corvo P, Barone JE, Cecere J, **Tucker JB**, Blabey, RG. The efficacy of head and abdominal CT scans in trauma patients with Glasgow Coma Scores of ≥ 14. Annual Meeting, Connecticut Chapter, American College of Surgeons, Cromwell, CT, December, 1995.

Tucker JB, Foster L. A Case Study of the MEDS Database at The Stamford Hospital. Presentation at the national annual meeting of the Sachs Group, Chicago, April, 1995.

M. Clark Kearney

Redacted
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Email: Redacted

Home: Redacted
Office: Redacted
Fax: Redacted

SUMMARY

Senior human resource executive with experience in health care, human resources, operations and business development. Skilled at building sound relationships and leading teams to support organizational goals. Management responsibilities have included:

Compensation, Benefits, Labor Relations, Organizational Development, Quality Improvement, Employee Relations, Community Relations, Operations and Business Development

CAREER HISTORY

SAINT MARY'S HOSPITAL, Waterbury, CT **1/07 - present**

Vice President, Human Resources & Organizational Effectiveness

- Human Resource, Education, and Organizational Development responsibilities in a non-union environment of 1800 plus employees.

JOHNSON HEALTH NETWORK, Strafford, CT **8/00 - 12/06**

- Network Vice President to an integrated health system with 1,400 employees. RN's are unionized.
- Restored confidence to a beleaguered Human Resources function through a strong customer-focused plan.
- Reduced the RN vacancy rate from 13% to 3% with special recruitment/retention programs.
- Headed an organizational development effort to increase customer satisfaction. Satisfaction increased from the 30th percentile to the 70th percentile in one year.
- Implemented a self-insured workers compensation program which reduced the annual expense from $800,000 to $450,000.
- Recruited ten attending physicians (Urology, Surgery, etc.) to strengthen the Hospital's marketing position.

MIDSTATE MEDICAL CENTER, Meriden, CT **1980-7/00**

Vice President, Business Development 1997 - 7/00

- Registered a 2% increase in market share by directly involving physicians in marketing.
- Increased the community approval rate of the hospital from 43% to 80% by implementing a comprehensive community relations strategy.

MIDSTATE MEDICAL CENTER (continued)

Vice President Administration, Human Resources 1980-1998

- Built a for-profit hospital business to $12 million annual revenue from $4 million.
- Led customer satisfaction change effort. Produced dramatic changes in customer ratings. Hospital now ranks in the 96th percentile of U.S. hospitals. (Press-Ganey Survey)
- Implemented first hospital management incentive system in Connecticut.
- Negotiated successful labor agreements in a previously adversarial environment.
- Increased employee retention by implementing a system-wide transfer policy which consolidated pension coverage.
- Implemented a performance based downsizing policy from a longevity system.
- Created an integrated delivery system which currently manages $8 million in risk contracts.

NEW BRITAIN GENERAL HOSPITAL, *Director of Personnel 1974-1980*

CONNECTICUT MUTUAL LIFE, *Employment Specialist 1972-1974*

UNITED STATES ARMY, *1st Lieutenant 1969-1972*

EDUCATION

M.S., Management, Hartford Graduate Center, Hartford, CT
M.S., Education, University of Southern California, Los Angeles, CA
B.A., Bates College, Lewiston, ME

PROFESSIONAL

Chairman, Zoning Board of Appeals
Former faculty, Graduate Program, *Management, Labor Relations,* Hartford Graduate Center

Charles M. Flinn, MBA, FACHE

Vice President-Chief Operating Officer
Saint Mary's Health System

In January 2014, Charles Flinn joined Saint Mary's Health System as Vice President-Chief Operating Officer. Flinn's expertise in healthcare is built on more than 25 years of progressive leadership in a variety of clinical, academic, and administrative positions. He brings with him a significant depth and breadth of health care experience and a sustaining commitment to the delivery of quality patient care.

In his role in New York, Flinn then the Chief Operating Officer, led HealthAlliance of the Hudson Valley in consolidating their two campuses (one secular and one Catholic) into a contemporary health care delivery system. Flinn's leadership, experience in operational process redesign, and commitment to network development has been instrumental in turning around the perceived community threat of a changing community hospital environment. His extensive knowledge of health care management issues, including prudent oversight of organizational dollars in services best geared for the community, has enabled him to position the HealthAlliance for today's competitive health care market.

Mr. Flinn was recruited to Saint Clare's Health System in 2005 as the Chief Administrative Officer. SCHS was a 500-bed teaching system that was financially challenged with annual losses approaching $7M. Utilizing his six sigma acumen, Flinn aligned with strategic partners (GE, Johnson Controls, Navigant), to lead a dynamic team, whom, within 18-months, had turned the system around and was breaking even through revenue reviews, facilities efficiencies and operational enhancements. Further improvements were identified in the operating room utilization, staff education, growing of market share, improving patient services and building the Country's number one ranked emergency department in overall satisfaction in 2007.

Flinn is a past Adjunct Faculty member at Touro College's School of Allied Health, an Associate member with the College of Healthcare Executives, and recently served on the Advisory Board for the Graduate Program in Health Care Management at the College of Saint Elizabeth in Morristown, NJ. He earned his bachelor's degree in Health Services Administration from Saint Joseph's College and his MBA from Dowling College.

Steven E. Schneider MD, MBA

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Home: Redacted
Cell: Redacted
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Objectives:

- To lead a healthcare organization
- To continue my own professional growth and development

Profile:

I am an experienced senior hospital executive with a proven record in direct operations management, physician leadership, manager care contracting, marketing, and management of quality and patient safety initiatives. I believe my enthusiastic and collaborative style, combined with my experience; make me well prepared to lead an organization looking for positive change and growth.

Professional Experience:

***Saint Mary's Hospital* – Waterbury, Connecticut** **2011 – Present**
Chief Medical Officer Saint Mary's Hospital
President of Franklin Medical Group

***Waterbury Hospital* – Waterbury, Connecticut** **1989 – 2011**
Waterbury Hospital Description:

- 15,000 admissions, 10,000 surgical procedures 56,000 ED visits per year
- Not for profit, community hospital
- Residencies in Internal Medicine (Yale Affiliated) and General Surgery (Yale and UCONN Affiliated)
- Level 2 Trauma Center

Direct Reports at Waterbury Hospital:

- Chairs of All Medical and Surgical Departments
- Director of Emergency Department Nursing
- Director of Case Management
- Chief Quality and Safety Officer
- Director of Marketing and Community Relations
- President of Alliance Medical Group
  (Hospital owned multispecialty physician group)
- Chief Medical Officer of Alliance Medical Group
- Director of Managed Care Contracting (from 1995-2000)

Accomplishments:
Vice President for Medical Affairs/Chief Medical Officer **1994 - Present**

- Chair, Board of Directors, Heart Center of Greater Waterbury:
  - Led, along with many others, the creation and approval of the first new Open Heart Surgery and Angioplasty program approved in Connecticut in nearly 20 years;

  - First program approved as a joint program between 2 competing hospitals
  - As Chair, successfully worked with members of the 2 hospital consortium through a very challenging Certificate of Need process
- Leadership of hospital marketing, advertising, and community relations departments:
  - Created very successful campaign marketing Orthopedic services with more than half of joint replacements coming from areas beyond our primary and secondary service areas
  - Developed, in conjunction with a partnering hospital, a huge and successful multimedia, community grass roots, and political strategy and campaign to win approval for a joint open heart and angioplasty program
- Created one of the first Hospitalist programs in Connecticut:
  - 10 years in operation; grown from 5 to 15 physicians
  - Covers more than half of all inpatients
  - Superior ALOS and quality parameters compared with private service
  - and teaching service patients
- Built and led hospital – owned physician group:
  - Grown over 15 years from a 4 physician primary care group to a Multispecialty group of more than 50 physicians and surgeons
  - Annual revenues of >$15 million; cost per physician lower than the 25th
  - percentile MGMA benchmark
- Started Waterbury Hospital's case management program:
  - Greater than 10 year track record of shortened lengths of stay
  - Greatly improved clinical documentation accuracy with revenue improvements of greater than $1 million per year
- Oversaw managed care contracting on behalf of Waterbury Hospital and the 300 plus physicians in a PHO
- Led complete turnaround of Physician and Nursing Leadership and all Physician staff of the Waterbury Hospital Emergency Department:
  - Changed from no EM Board Certified physician to All EM Board Certified
  - ED volume grew from 40,000 visits to over 56,000 visits per year
  - ED now has a positive contribution margin of $5-$10 million annually

Chairman Department of Psychiatry 1989-1994

- Full operational and budget responsibility for all aspects of a very large program with greater than 50,000 outpatient visits and 1000 inpatient admissions per year
- Redesigned department from one large service to sub-specialty service lines leading to significant improvements in service quality and in payor mix
- Implemented aggressive utilization management and clinical pathways leading to the publication of an article in a peer reviewed journal featuring our specialty ultra-short length of stay inpatient unit

***Allegheny General Hospital* – Pittsburgh, Pennsylvania** **1985-1989**

Acting Medical Director, Allegheny Neuropsychiatric Institute 1988-1989

- Assumed leadership of Allegheny Neuropsychiatric Institute (ANI), a freestanding subsidiary of Allegheny General Hospital at the request of AGH CEO after unexpected departure of both AGH's Department Chair/Founder of ANI and the Medical Director of ANI just after the facility opened.
  - Brought stable leadership to a very chaotic situation
  - Provided credible clinical programming to external referring hospitals
  - Recruited excellent clinical staff in a challenging environment

Chief, Inpatient Psychiatry Allegheny General Hospital/Medical College of Pennsylvania 1985-1988

- Facilitated growth of Inpatient Service from 16-28 beds
- Led change in treatment approaches toward more practical and modern neuropsychiatric and biologic treatment protocols

United States Army Medical Officer **1977-1982**

- Attained rank of Major, U.S. Army Medical Corps

***Martin Army Hospital* – Ft. Benning, Georgia** **1980-1982**

Chief, Emergency Medicine Service

- Totally restructured E.R. service organization resulting in dramatic improvement in quality and efficiency of services
- Awarded Army Commendation Medal for the above
- Introduced Advanced Trauma Life Support Courses and Certification to the hospital
- Established respected Family Practice resident rotation in Emergency Medicine

Ft. Lewis/Madigan Army Medical Center – Ft. Lewis, Washington **1978-1979**

Brigade Surgeon, 9th Infantry Division, 3rd Brigade

Education:

1994-1995 University of New Haven, MBA
1982-1985 Yale University School of Medicine, Residency in Psychiatry
1979-1980 Madigan Army Medical Center, Residency in Emergency Medicine
1977-1978 Madigan Army Medical Center, Internship, pre Emergency Medicine
1974-1977 University of Nebraska, College of Medicine, MD
1970-1974 University of Nebraska BA Biology, Magna Cum Laude

Licensure and Certification:
Connecticut Medicine and Surgery
American Board of Psychiatry and Neurology

Academic Publications:
Schneider, SE and Ross, IM. The Effectiveness of Ultra-Short Length of Stay Admission in a Comprehensive Managed Care System. Psychiatric Services, Vol. 47: No. 2, p. 137-138, 1996.

Schneider, SE and Phillips, WM. Depression and Anxiety in Medical, Surgical, and Pediatric Interns. Psychological Reports. 72:1145-1146, 1993.

Yudofsky, SC, Silver, JM, Schneider, SE. The Use of Beta Blockers in the Treatment of Aggression. Psychiatry Letter. Fair Oaks Hospital. Spring/Summer, Vol. 6, Issue 1-6, 1988.

Yudofsky, SC, Silver, JM, Schneider, SE. Pharmacologic Treatment of Aggression. Psychiatry Annals. 17, (6): 397-407, 1987.

Academic Positions:

Assistant Clinical Professor of Psychiatry, Yale University	1991-2000
Adjunct Clinical Assistant Professor, Quinnipiac College	1997-2002
Assistant Professor of Psychiatry, Medical College of Pennsylvania	1987-1989
Clinical Instructor in Emergency Medicine, US Army Academy Of Health Sciences	1981-1982

Professional Organization:
American College of Healthcare Executives
American College of Physician Executives
American Medical Association
Waterbury Medical Society

Community Activities:
Past Trustee Waterbury YMCA
Volunteer Mentor in Waterbury School System
Member of Visions Task Force, City of Waterbury
Acting Director of Health Department, City of Waterbury
Incorporator, Child Guidance Clinic of Waterbury

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CURRICULUM VITAE

KELVIN A. BAGGETT, M.D., M.P.H., M.B.A., F.A.C.P., F.A.C.H.E.

OFFICE ADDRESS

TELEPHONE NUMBERS

HOME ADDRESS

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.

Mark R. Montoney, MD, MBA

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

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

Erik G. Wexler

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

Y

Name Entity:
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:

LINE	Total Entity:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		FY 2013	FY 2014	FY 2014	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	Projected	Projected
	Description	Results	W/out CON	Incremental	With 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	$670,163	$725,561		$725,561	n/a		n/a	n/a		n/a	n/a		n/a
2	Less: Allowances	$401,170	$450,642		$450,642	n/a		n/a	n/a		n/a	n/a		n/a
3	Less: Charity Care	$94	$250		$250	n/a		n/a	n/a		n/a	n/a		n/a
4	Less: Other Deductions	$0	$0		$0	n/a		n/a	n/a		n/a	n/a		n/a
	Net Patient Service Revenue	$268,899	$274,669	$0	$274,669	$0	$0	$0	$0	$0	$0	$0	$0	$0
5	Medicare	$103,750	$104,923		$104,923	$0		$0	$0		$0	$0		$0
6	Medicaid	$67,601	$72,787		$72,787	$0		$0	$0		$0	$0		$0
7	CHAMPUS & TriCare	$500	$549		$549	$0		$0	$0		$0	$0		$0
8	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Government	$171,851	$178,259	$0	$178,259	$0	$0	$0	$0	$0	$0	$0	$0	$0
9	Commercial Insurers	$83,103	$84,049		$84,049	$0		$0	$0		$0	$0		$0
10	Uninsured	$0	$0		$0	$0		$0	$0		$0	$0		$0
11	Self Pay	$7,409	$5,219		$5,219	$0		$0	$0		$0	$0		$0
12	Workers Compensation	$6,536	$7,142		$7,142	$0		$0	$0		$0	$0		$0
13	Other	$0	$0		$0	$0		$0	$0		$0	$0		$0
	Total Non-Government	$97,048	$96,410	$0	$96,410	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue* (Government+Non-Government)	$268,899	$274,669	$0	$274,669	$0	$0	$0	$0	$0	$0	$0	$0	$0
14	Provision for Bad Debts	$12,878	$11,461		$11,461	$0		$0	$0		$0	$0		$0
	Net Patient Service Revenue less provision for bad debts	$256,021	$263,208	$0	$263,208	$0	$0	$0	$0	$0	$0	$0	$0	$0
15	Other Operating Revenue	$7,864	$9,786		$9,786	$0		$0	$0		$0	$0		$0
17	Net Assets Released from Restrictions				$0			$0			$0			$0
	TOTAL OPERATING REVENUE	$263,885	$272,994	$0	$272,994	$0	$0	$0	$0	$0	$0	$0	$0	$0
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$108,933	$110,427		$110,427	$0		$0	$0		$0	$0		$0
2	Fringe Benefits	$31,305	$28,972		$28,972	$0		$0	$0		$0	$0		$0
3	Physicians Fees	$8,207	$8,297		$8,297	$0		$0	$0		$0	$0		$0
4	Supplies and Drugs	$38,194	$40,131		$40,131	$0		$0	$0		$0	$0		$0
5	Depreciation and Amortization	$10,052	$9,930		$9,930	$0		$0	$0		$0	$0		$0
6	Provision for Bad Debts-Other**	$8	$0		$0	$0		$0	$0		$0	$0		$0
7	Interest Expense	$1,598	$1,465		$1,465	$0		$0	$0		$0	$0		$0
8	Malpractice Insurance Cost	$8,292	$6,358		$6,358	$0		$0	$0		$0	$0		$0
9	Lease Expense	$6,145	$6,082		$6,082	$0		$0	$0		$0	$0		$0
10	Other Operating Expenses	$42,469	$52,055		$52,055	$0		$0	$0		$0	$0		$0
	TOTAL OPERATING EXPENSES	$255,203	$263,717	$0	$263,717	$0	$0	$0	$0	$0	$0	$0	$0	$0
	INCOME/(LOSS) FROM OPERATIONS	$8,682	$9,277	$0	$9,277	$0	$0	$0	$0	$0	$0	$0	$0	$0
	NON-OPERATING INCOME / REVENUE	$1,758	$1,256		$1,256	$0		$0	$0		$0	$0		$0
	Income before provision for income taxes	$10,440	$10,533	$0	$10,533	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Provision for income taxes				$0			$0			$0			$0
	NET INCOME / EXCESS(DEFICIENCY)OF REVENUE OVER EXPENSES	$10,440	$10,533	$0	$10,533	$0	$0	$0	$0	$0	$0	$0	$0	$0
C.	**Retained Earnings, beginning of year**	$20,537	$52,928		$52,928	$60,000		$60,000	$60,000		$60,000	$60,000		$60,000
	Retained Earnings, end of year	$52,928	$60,000		$60,000	$60,000		$60,000	$60,000		$60,000	$60,000		$60,000
	Principal Payments	$2,268	$2,490		$2,490	$2,509		$2,509	$2,338		$2,338	$2,310		$2,310
D.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	3.3%	3.4%	0.0%	3.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2	Hospital Non Operating Margin	0.7%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3	Hospital Total Margin	3.9%	3.8%	0.0%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
E.	**FTEs**	0	0		0	0		0	0		0	0		0
F.	*****VOLUME STATISTICS**													
1	Inpatient Discharges	0	0		0	0		0	0		0	0		0
2	Outpatient Visits	219,267	220,214		220,214	221,315		221,315	222,422		222,422	223,534		223,534
	TOTAL VOLUME	219,267	220,214	0	220,214	221,315	0	221,315	222,422	0	222,422	223,534	0	223,534

*Total amount should equal the total amount on cell line "Net Patient Revenue" row 14.
*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For aditional information, refer to FASB, No.2011-07, July 2011.
**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.

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 adjustment factor each year;
    c. Average hourly wage increase of 2.0% each year;
    d. Employee productivity is expected to improve by 0.5% each year;
    e. Net patient revenue per adjusted discharge increase of 2% each year;
    f. Bad Debt Expense remains consistent at 4.2% of net patient service revenues;
    g. Increase of 3% in supplies and drugs pricing each year;
    h. Inflation 2% each year; and
    i. Increase of 1% for other operating revenues each year.

2. Other Factors/Assumptions/Adjustments for FY15:
    a. $3.3 million cut in Medicare due to wage index;
    b. $5.0 million cut in Medicaid DSH payments;
    c. $3.7 million increase as a result of CDI improvement and charge capture;
    d. $9.4 million increase in net revenues as a result of full year of Oncology and Physician practice, offset by decrease in Children's Health Center which will be transfer to Staywell (FQHC);
    e. Bad Debt Expense remains consistent at 4.2% of net patient service revenues;
    f. Other operating Revenue decrease from FY14 to FY15 as a result of reductions in grant revenue and meaningful use incentives;
    g. Salaries increase as a result of additional FTEs related to new practices;
    h. Benefits remain consistent at approximately 26% of wages;
    i. Supplies and Drugs increased due to full year of Oncology department drugs offset by supply cost initiative savings;
    j. Interest expense decrease as debt is reduced;
    k. Other operating Expenses increase by approximately $300k as a result of full year of new practice expenses.; and
    l. Non-operating income increases $750k as a result of expected increase earnings in joint venture income.

3. Other Factors/Assumptions/Adjustments for FY16:
    a. $2.5 million cut in Medicare due to wage index.

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 adjustment factor each year;
    c. Average hourly wage increase of 2.0% each year;
    d. Employee productivity is expected to improve by 0.5% each year;
    e. Net patient revenue per adjusted discharge increase of 2% each year;
    f. Bad Debt Expense remains consistent at 4.2% of net patient service revenues;
    g. Increase of 3% in supplies and drugs pricing each year;
    h. Inflation 2% each year; and
    i. Increase of 1% for other operating revenues each year.
2. Adjustments to financials resulting from CON
    a. Estimated sales and property taxes are layered into the projected years;
    b. Other operating expenses are reduced by approximately $3.9M due to reducing outsourced services that Tenet would provide on a go forward basis;
    c. Salaries and benefits are adjusted for business office efficiencies.
    d. Fringe benefits expense is reduced by approximately $2.3M as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    e. Pension contributions are deducted from Fringe Benefits;
    f. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    g. Interest expense is reduced to $0 as the standalone entity will not be levered; and
    h. Income tax layered into the expense structure assuming a 40% income tax rate.

Z

002394

Name Entity:
Financial Attachment I (B):

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:

LINE	Total Entity:	(1)	(2)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
		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
A.	**OPERATING REVENUE**											
1	Total Gross Patient Revenue	$670,163	$725,561	$753,014	$7,549	$760,563	$761,319	$15,341	$776,660	$776,526	$23,590	$800,115
2	Less: Allowances	$401,170	$450,642	$467,693	$4,689	$472,381	$472,851	$9,528	$482,379	$482,296	$14,651	$496,947
3	Less: Charity Care	$94	$250	$259	$3	$262	$262	$5	$268	$268	$8	$276
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	$268,899	$274,669	$285,061	$2,858	$287,919	$288,205	$5,808	$294,013	$293,962	$8,930	$302,892
5	Medicare	$103,750	$104,923	$110,815	$1,095	$111,911	$110,479	$2,226	$112,705	$112,685	$3,423	$116,109
6	Medicaid	$67,601	$72,787	$70,856	$717	$71,572	$72,271	$1,456	$73,727	$73,714	$2,239	$75,954
7	CHAMPUS & TriCare	$500	$549	$577	$6	$583	$589	$12	$601	$601	$18	$619
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	$171,851	$178,259	$182,248	$1,818	$184,066	$183,338	$3,694	$187,033	$187,000	$5,681	$192,681
9	Commercial Insurers	$83,103	$84,049	$89,702	$907	$90,609	$91,493	$1,844	$93,337	$93,321	$2,835	$96,156
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$7,409	$5,219	$5,534	$56	$5,590	$5,645	$114	$5,759	$5,758	$175	$5,933
12	Workers Compensation	$6,536	$7,142	$7,577	$77	$7,654	$7,729	$156	$7,884	$7,883	$239	$8,123
13	Other	$0	$0	$0		$0	$0		$0	$0		$0
	Total Non-Government	$97,048	$96,410	$102,813	$1,040	$103,853	$104,867	$2,113	$106,980	$106,962	$3,249	$110,211
	Net Patient Service Revenue* (Government+Non-Government)	$268,899	$274,669	$285,061	$2,858	$287,919	$288,205	$5,808	$294,013	$293,962	$8,930	$302,892
14	Provision for Bad Debts	$12,878	$11,461	$11,895	$119	$12,014	$12,026	$242	$12,268	$12,266	$373	$12,639
	Net Patient Service Revenue less provision for bad debts	$256,021	$263,208	$273,167	$2,739	$275,905	$276,180	$5,565	$281,745	$281,696	$8,557	$290,254
15	Other Operating Revenue	$7,864	$9,786	$9,076	$0	$9,076	$9,167	$0	$9,167	$9,258	$0	$9,258
17	Net Assets Released from Restrictions					$0			$0			$0
	TOTAL OPERATING REVENUE	$263,885	$272,994	$282,243	$2,739	$284,981	$285,346	$5,565	$290,912	$290,954	$8,557	$299,512
B.	**OPERATING EXPENSES**											
1	Salaries and Wages	$108,933	$110,427	$115,542	983	$116,526	$117,261	$2,013	$119,274	$119,005	$3,265	$122,271
2	Fringe Benefits	$31,305	$28,972	$29,815	($6,883)	$22,932	$30,258	($6,723)	$23,535	$30,709	($6,508)	$24,201
3	Physicians Fees	$8,207	$8,297	$8,463	$0	$8,463	$8,632	$0	$8,632	$8,805	$0	$8,805
4	Supplies and Drugs	$38,194	$40,131	$42,225	$521	$42,746	$43,490	$977	$44,468	$44,794	$1,465	$46,259
5	Depreciation and Amortization	$10,052	$9,930	$10,135	($3,407)	$6,728	$10,337	($3,093)	$7,244	$10,544	($2,763)	$7,781
6	Provision for Bad Debts-Other**	$8	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$1,598	$1,465	$1,392	($1,392)	$0	$1,318	($1,318)	$0	$1,243	($1,243)	$0
8	Malpractice Insurance Cost	$8,292	$6,358	$6,485	$0	$6,485	$6,615	$0	$6,615	$6,747	$0	$6,747
9	Lease Expense	$6,145	$6,082	$6,204	$0	$6,204	$6,328	$0	$6,328	$6,454	$0	$6,454
10	Other Operating Expenses	$42,469	$52,055	$53,391	($382)	$53,008	$54,459	($390)	$54,069	$55,548	($398)	$55,150
	TOTAL OPERATING EXPENSES	$255,203	$263,717	$273,652	($10,560)	$263,092	$278,699	($8,534)	$270,165	$283,849	($6,182)	$277,667
	INCOME/(LOSS) FROM OPERATIONS	$8,682	$9,277	$8,591	$13,298	$21,889	$6,647	$14,100	$20,747	$7,106	$14,739	$21,845
	NON-OPERATING INCOME / REVENUE	$1,758	$1,256	$2,046	$0	$2,046	$2,087	$0	$2,087	$2,129	$0	$2,129
	Income before provision for income taxes	$10,440	$10,533	$10,637	$13,298	$23,935	$8,734	$14,100	$22,834	$9,234	$14,739	$23,974
	Provision for income taxes				$9,574	$9,574		$9,134	$9,134		$9,589	$9,589
	NET INCOME / EXCESS(DEFICIENCY)OF REVENUE OVER EXPENSES	$10,440	$10,533	$10,637	$13,298	$23,935	$8,734	$14,100	$22,834	$9,234	$14,739	$23,974
C.	**Retained Earnings, beginning of year**	$20,537	$52,928	$60,000	$0	$60,000	$70,637	$13,298	$83,935	$79,371	$27,398	$106,769
	Retained Earnings, end of year	$52,928	$60,000	$70,637	$13,298	$83,935	$79,371	$27,398	$106,769	$88,606	$42,137	$130,742
	Principal Payments	$2,268	$2,490	$2,509	($2,509)	$0	$2,338	($2,338)	$0	$2,310	($2,310)	$0
D.	**PROFITABILITY SUMMARY**											
1	Hospital Operating Margin	3.3%	3.4%	3.0%	485.6%	7.6%	2.3%	253.4%	7.1%	2.4%	172.2%	7.2%
2	Hospital Non Operating Margin	0.7%	0.5%	0.7%	0.0%	0.7%	0.7%	0.0%	0.7%	0.7%	0.0%	0.7%
3	Hospital Total Margin	3.9%	3.8%	3.7%	485.6%	8.3%	3.0%	253.4%	7.8%	3.2%	172.2%	7.9%
E.	**FTEs**	1,583	1,554	1,557	(1)	1,556	1,549	(2)	1,547	1,541	14	1,555
F.	*****VOLUME STATISTICS**											
1	Inpatient Discharges	11,744	11,767	11,708	59	11,767	11,650	117	11,767	11,591	176	11,767
2	Outpatient Visits	219,267	220,214	221,315	1,101	222,416	222,422	2,219	224,640	223,534	3,353	226,887
	TOTAL VOLUME	231,011	231,981	233,023	1,160	234,183	234,071	2,336	236,407	235,125	3,529	238,654

*Total amount should equal the total amount on cell line "Net Patient Revenue" row 14.
*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For aditional information, refer to FASB, No.2011-07, July 2011.
**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.

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 adjustment factor each year;
    c. Average hourly wage increase of 2.0% each year;
    d. Employee productivity is expected to improve by 0.5% each year;
    e. Net patient revenue per adjusted discharge increase of 2% each year;
    f. Bad Debt Expense remains consistent at 4.2% of net patient service revenues;
    g. Increase of 3% in supplies and drugs pricing each year;
    h. Inflation 2% each year; and
    i. Increase of 1% for other operating revenues each year.

2. Other Factors/Assumptions/Adjustments for FY15:
    a. $3.3 million cut in Medicare due to wage index;
    b. $5.0 million cut in Medicaid DSH payments;
    c. $3.7 million increase as a result of CDI improvement and charge capture;
    d. $9.4 million increase in net revenues as a result of full year of Oncology and Physician practice, offset by decrease in Children's Health Center which will be transfer to Staywell (FQHC);
    e. Bad Debt Expense remains consistent at 4.2% of net patient service revenues;
    f. Other operating Revenue decrease from FY14 to FY15 as a result of reductions in grant revenue and meaningful use incentives;
    g. Salaries increase as a result of additional FTEs related to new practices;
    h. Benefits remain consistent at approximately 26% of wages;
    i. Supplies and Drugs increased due to full year of Oncology department drugs offset by supply cost initiative savings;
    j. Interest expense decrease as debt is reduced;
    k. Other operating Expenses increase by approximately $300k as a result of full year of new practice expenses.; and
    l. Non-operating income increases $750k as a result of expected increase earnings in joint venture income.

3. Other Factors/Assumptions/Adjustments for FY16:
    a. $2.5 million cut in Medicare due to wage index.

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 adjustment factor each year;
    c. Average hourly wage increase of 2.0% each year;
    d. Employee productivity is expected to improve by 0.5% each year;
    e. Net patient revenue per adjusted discharge increase of 2% each year;
    f. Bad Debt Expense remains consistent at 4.2% of net patient service revenues;
    g. Increase of 3% in supplies and drugs pricing each year;
    h. Inflation 2% each year; and
    i. Increase of 1% for other operating revenues each year.
2. Adjustments to financials resulting from CON
    a. Estimated sales and property taxes are layered into the projected years;
    b. Other operating expenses are reduced by approximately $3.9M due to reducing outsourced services that Tenet would provide on a go forward basis;
    c. Salaries and benefits are adjusted for business office efficiencies.
    d. Fringe benefits expense is reduced by approximately $2.3M as Tenet will provide a benefit plan more cost effectively as a result of greater purchasing power;
    e. Pension contributions are deducted from Fringe Benefits;
    f. Depreciation and Amortization expense is based upon a blended useful life of 14 years;
    g. Interest expense is reduced to $0 as the standalone entity will not be levered; and
    h. Income tax layered into the expense structure assuming a 40% income tax rate.

AA

Nurse Staffing Plan
Saint Mary's Hospital

The hospital plan to provide nursing care at Saint Mary's Hospital is developed through a comprehensive process that draws upon multiple sources of data and input from registered nurses and other hospital staff members. The staffing plan is continuously evaluated throughout the year and formally reviewed and updated annually. The annual staffing plan reflects budgeted, core staffing levels for inpatient units including critical care, and the emergency department. Actual staffing is adjusted on a daily or more frequent basis to meet patient care needs and is evaluated weekly through the use of a productivity measurement system.

Considerations in Staffing Plan Development and Decisions

A broad range of factors are considered in the development of the core staffing plan and ongoing staffing adjustments, many of which are embodied in the American Nurses Association's (ANA) Principles for Nurse Staffing. Staffing plan development and decisions are carried out with consideration given to patient characteristics and patient severity of illness, the number of patients for whom care is provided, levels of individual patient as well as unit intensity, the geography/physical layout of the patient care unit, available technology, and level of preparation and experience of those providing care, among others.

In addition to the factors described above, Saint Mary's Hospital considers historical staffing and patient data, staff input, patient care support services, and any plans for new programs, when developing the annual staffing plan.

1. **Professional Skill Mix For Patient Care units**
The professional skill mix staffing plan for each patient care unit is articulated in this hospital plan for nursing care. The Master Staffing Plan reflects the required nursing hours of care or the nursing personnel necessary to deliver care. Criteria have been established to review and evaluate the department's adherence to the plan. This criterion includes a weekly review of the variance of worked hours per unit of service to the target worked hours per unit of service. In addition, criteria have been established for each unit to determine when staffing levels are to be adjusted. This criterion includes the following: changes in census or volume (higher or lower than expected); changes in patient workload or patient condition; skill mix of care givers (appropriate number of RN's compared to Graduate Nurses or inexperienced RN's or LPN's); or staff level of competency in a specialty area. The Master Staffing plan is adjusted as necessary to meet patient care needs based on severity of illness of patients, workload distribution, and specialization of the unit. These adjustments may be accomplished by utilizing per diem staff, internal float pool personnel, on call staff, unit to unit floating/transfer or the over-scheduling of current staff.

2. **Use of Temporary and Traveling Staff Nurses**
Saint Mary's Hospital utilizes temporary/traveling staff nurses when necessary to ensure adequate levels of staffing to provide safe patient care. Such instances may include the inability to fill budgeted staff registered nurse positions due to shortages and limited availability of nurses with specific types and levels of expertise, and the need to temporarily fill positions when staff members are on leave. Efforts to schedule hospital employed per

diem and other staff are made to fill vacant budgeted positions as appropriate when needs are short term prior to consideration of the use of temporary and traveling staff.

3. **Administrative Staffing**
   The annual staffing plan is developed to provide adequate direct care staff for forecasted patient care needs exclusive of nurse managers and inclusive of appropriate clerical support.

4. **Review of the Nurse Staffing Plan**
   A review is performed on a weekly basis through the use of a productivity measurement system which evaluates variance between the actual staffing (worked hours per unit of service) as compared to national benchmark targets.

   The staffing plan that reflects core staffing levels is formally established and reviewed annually and re-evaluated, as necessary, throughout the year. Review of the factors articulated in the section *Considerations in Staffing Plan Development and Decisions* above is conducted through a combination of unit staff meetings, Nurse Practice Council meetings, and Nursing Executive Council meetings.

5. **Direct Care Staff Input**
   Direct care staff input regarding the staffing plan is solicited via unit based staffing meetings, Nurse Practice Council meetings.

Certification
This hospital plan for nursing care has been developed through consideration of anticipated patient population care needs, unit geography, technology and support, and competency/expertise required of staff providing care. It has been reviewed and discussed by unit staff, Nurse Practice Council and the Nursing Executive Council and is appropriate for the provision of patient care as forecasted.

BB

DATE: April 15, 2014

SUBJECT: Saint Mary's CARE

PURPOSE: Recognizing its charitable mission, it is the policy of Saint Mary's to provide a reasonable amount of its services without charge to eligible patients who cannot afford to pay for care. To assist in this regard, Saint Mary's offers a program that offers financial assistance to those who show a financial need. A CARE and discounted balance program will be established once each year during the annual budget process and submitted to the Board of Directors for approval. While there is a budgeted amount for this program, the need for financial assistance for the patients will take precedence over a fixed budget amount.

POLICY: To insure that the Hospital's resources are used by those who need them most, our staff members will help patients explore all other options for financial assistance prior to offering assistance with the CARE program. If it is determined that benefits are not available, our staff members will assist any interested patient in completing the CARE program guidelines. If a patient is determined eligible, discounted care will be provided to uninsured and underinsured patients. All self-pay accounts will be eligible for 40% off of the published charges. If approved CARE applications exceed the budgeted amount, the Board will be immediately notified. As a part of this process, a formal appeal process will be conducted whereby all appealed CARE denials will be reviewed by the Director of Patient Access or the Corporate Director of Revenue Cycle.

DEFINITIONS:

Catastrophic Illness: Catastrophic illness is any medical condition, either acute or chronic, with incurred expenses that are not fully covered by private insurance and/or local or federal programs, or other sources. This also includes expenses that exceed the patients' maximum benefits. Patients will be eligible for discounted care if their balance exceeds 25% of their gross monthly income.

Earned Income: Earned income is the sum of all household wages or salaries received on a weekly, monthly or annual basis.

PROCEDURE:

1. Saint Mary's CARE and discounted care include services provided to the following groups of

people:

- Uninsured or underinsured low-income patients who do not have the ability to pay all or part of their bill as determined by the financial guidelines of this policy.
- Insured patients whose coverage is inadequate to cover a catastrophic situation.
- Patients who may be able to afford basic living costs but cannot handle the additional burden of healthcare costs, and who do not qualify for Medicaid.

2. All self-pay accounts will be eligible for a 40% self-pay discount of the published charges regardless of income or assets. All accounts must be in the self-pay financial class for the discount to be implemented.

3. Patient receiving elective cosmetic procedures is not eligible for CARE assistance.

4. Unless the patient has a catastrophic illness and the balances are greater than 25% of the gross monthly income, insured patients with balances due to deductibles, copayments, coinsurance amounts or non-covered charges are not eligible for CARE.

5. Other eligible groups of patients:
   - Those who have applied and have been compliant in an attempt to obtain any type of health care coverage, but have been denied.
   - Patients who are not eligible for coverage under Medicare, Tricare or any other federal program.
   - Patients who have been denied coverage by private or accidental insurance coverage, including, but not limited to Workers' Compensation, settlements or judgments arising from suits, and claims or proceedings involving motor vehicle accidents or alleged negligence.

6. A patient may only request CARE while the account(s) is still an active receivable.

7. Incomplete applications and falsified applications will not be considered for CARE.

8. The patient's gross income and family size will be considered in determining eligibility for CARE. If the patient is a minor, total income earned in the household will be considered when determining eligibility for CARE.

9. Patients found eligible for CARE will not only be eligible for care for any balance due at the time of the application approval, but also for any medically necessary services rendered within the six months prior to, and within six months after the application approval date.

10. Patients will be given a discount card that states their period of eligibility (six month). During this period of time it will not be mandatory for them to complete a new application or provide proof of their income; however Saint Mary's reserves the right to requested update income information, during this six month period.

11. Patients whose income levels are at or below 400% of the Federal Poverty Income Levels will be considered for CARE assistance. A sliding fee scale will be implemented applied at 350% of the Federal Poverty Income levels.

12. Signage (in 48 or 72 font), with a one page summary describing the STMH CARE program will be written in the English, Spanish, Portuguese and Albanian languages. These signs will be placed in the following areas throughout the hospital:

- Patient Access
- Emergency Department
- All Social Service Departments
- Patient Financial Services
- Cashiers' Office
- Financial Advocate work area
- Lobby

13. Saint Mary's CARE does not include bad debt, contractual adjustments or unreimbursed costs from other community services. The financial status of each patient needs to be verified to determine an appropriate and accurate classification and distinction between CARE accounts and bad debt accounts. (CARE accounts are established due to the patient's ***inability*** to pay, whereas bad debt accounts are classified as such due to the patients' ***refusal*** to pay the balances on their accounts).

14. The following factors are to be considered and calculated when determining the amount of CARE assistance for which a patient is eligible at the time of service (See Appendix A for a CARE Application):

- The patient's individual or family income, as appropriate, using the income guidelines as published by the Federal Government on April 1st of each year (Federal Income Guidelines: See Appendix B for the current year Federal Income Guidelines and Appendix C for the sliding fee scale)
- Family Size
- All other resources must be applied first, including the existence of and reimbursement from third party payers, reimbursement from other organizations such as the Victims of Crime (i.e., a state-level program for crime victims to recover partial hospital costs), and the Medicaid program. (If a patient does not have Medicaid but would qualify, he or she must cooperate with the application process. If the application is denied or is identified as ineligible based on the Medicaid income criteria, the patient should be considered for CARE or discounted care.

15. Determine the appropriate amount of CARE assistance in relation to the patient balance due after applying all other resources, if any. If a patient can afford to pay for a portion of the services, he/she will be expected to do so. The scenario is also possibly whereby the balance due would be resolved by all parties involved, these being the third party payer, the patient and the CARE program.

16. If the patient does not pay the amount determined to be his or her responsibility, the

uncollectible amount would become a bad debt.

17. In order to determine eligibility for the CARE program, the patient or guarantor must submit two pieces of documentation that will establish eligibility:

- Proof of income. For this, the patient can submit either a copy of the household income / paycheck(s), a copy of social security check(s), pension paperwork, unemployment or disability check stubs. A current or previous tax return can also be used to verify total household income. Any official documentation stating annual income will be considered.
- The family (or responsible party) must also complete and sign a CARE application form. All documentation needs to be submitted within 14 days prior to or after the date of service. Additional time for completion of the application process may be extended as appropriate and warranted

18. Eligibility should be determined as soon as possible. Applications can be approved at the time of admission or pre-registration, or as soon as possible thereafter. The awarding of full or partial CARE assistance cannot be determined until all documents have been reviewed and approved.

19. The CARE applications need to be processed within three business days from when the ***completed*** application has been received. At that time, the patient needs to be notified in writing regarding, (See Appendix D) any additional documents that may be required, their qualification for CARE, how the balance due will be resolved and any expected repayment terms, if any. At this time, the Financial Advocates will determine the write-off amount based on the aforementioned guidelines, and will also determine the proper contractual adjustment code as seen in Appendix E).

20. If approved, the Financial Advocates will then forward the write-off information to the appropriate member of management based on the size of the balance to be written off. Denials will also be forwarded following the same protocol, with the exception that denials over $50,000 will be reviewed by the Director of Patient Access or the Corporate Director of Revenue Cycle:

Balance to be Written Off:	**Approval by:**
Up to $1000	Financial Advocate
$1,001 to $9,999	Supervisor of Patient Access
$10,000 to $19,999	Manager of Patient Access
$20,000 - $49,999	Director of Patient Access
$50,000 and greater	Chief Financial Officer or Corporate Director of Revenue Cycle

21. Patient Advocate staff members will insure that the patients and physicians are notified, in writing, regarding the approval or denial of the application for the CARE program. Financial Advocates also need to inform the same parties of ongoing pending cases. This documentation will also include the appeal process of any denied application which is described in the next section.

22. As described, patients may appeal denied applications. The denial notification for each CARE and discounted care notification to the applicant will include examples of additional information that may be submitted to review an appealed case. The patient has 30 days from the date of the denial letter to appeal a case. Any information received regarding the denial will be reviewed by the Supervisor or Manager of Patient Access. Documentation stating that the case has either been upheld or reversed must be communicated to the patient within 15 days of receipt of the appeal.

23. CARE provisions can and will be re-evaluated for a patient's eligibility if there are changes in the patient's financial situation or other affected circumstances, i.e. the rendering of additional non-covered services, when there is a change(s) in household income or size, or when a previous applicant has had an account(s) transferred to bad debt. New applications should also be filed when six months have passed since the initial or previous application. It is, however, up to the patient to insure that this information is brought to supervisory attention to enable the reapplication process to occur.

24. The base level for the CARE and discounted care income eligibility is set at 45 percent.

25. The hospital will update the income eligibility criteria in April of each year. This process will occur as soon as the Federal Poverty Guidelines (FPG) are published by the Centers for Medicare and Medicaid (CMS). If CMS issues more than one update, the updated criteria will become effective as of the issue date.

26. Any questions or exception requests regarding this policy need to first be directed to the Manager(s) or Director of Patient Access.

REFERENCES:

The AHA Board of Trustees Statement of Principles and Guidelines on Hospital Billing and Collection Practices (http://www.aha.org/content/12/120505-bill-collec-prac-statement.pdf);

Internal Revenue Code Section 501® requirements for tax-exempt hospitals (http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120716-legal-adv.pdf).

CONTACT:

None

APPROVAL:

By: ______________________________

Title: Director of Patient Access

Date: ______________________________

By: ______________________________

Title: Corporate Director of Revenue Cycle

Date: ______________________________

By: ______________________________

Title: Chief Financial Officer

Date: ______________________________

EXHIBIT A: FINANCIAL ASSISTANCE APPLICATION

Patient Name: ______________________________ Date: ____________________

Current Address: Street____

City, State, Zip code: ____

Telephone Number (including area code):____________________________________

Account Number(s):____

Employer's Name & Address: ____

Spouse's Employer and Address: ____

Medical Insurance (Primary):____________________ Subscriber ID: ________________

Medical Insurance (Secondary, if any):______________ Subscriber ID: ________________

Number of Dependents (list ages, including self): ____________________________

____

Monthly Income (List source/amount): Patient's income (if any) ____________________

Parent Income______________ Spouse's Income: ______________________________

Other Income ____

I hereby attest that the above information is true and accurate. I understand that in order for me to be eligible, the information contained herein must be verified. I agree to provide Saint Mary's Hospital with the necessary verifications, and if requested, agree to cooperate and follow through with applications for State and/or Federal assistance as well as any other third party payers.

Patient/Guarantor: ______________________________ Date: ____________________

Financial Advocate: ______________ Approved by: ______________ Date:______________

- All income must be verified. Please provide last four pay stubs.
- If you are self-employed, please provide a complete copy of last year's filed Income Tax Return (including ALL schedules (i.e. for example, Schedule C).

* Please Note: We will notify physicians who are part of the Franklin Medical Group if it is determined that you are eligible for St. Mary's CARE.

CC

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: ST. MARY'S HOSPITAL, INC.
Employer identification number: 06-0646844

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 250.0000 %	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	X	
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		X
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)			93,747.		93,747.	.04
b Medicaid (from Worksheet 3, column a)			62,978,643.	51,642,221.	11,336,422.	5.12
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			63,072,390.	51,642,221.	11,430,169.	5.16
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		14818	277,269.		277,269.	.13
f Health professions education (from Worksheet 5)		592	17,380,618.	14,844,848.	2,535,770.	1.15
g Subsidized health services (from Worksheet 6)			24,246,612.	21,040,124.	3,206,488.	1.45
h Research (from Worksheet 7)			110,871.		110,871.	.05
i Cash and in-kind contributions for community benefit (from Worksheet 8)		21304	78,505.		78,505.	.04
j Total. Other Benefits		36714	42,093,875.	35,884,972.	6,208,903.	2.82
k Total. Add lines 7d and 7j		36714	105,166,265.	87,527,193.	17,639,072.	7.98

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			202.		202.	
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			158,600.		158,600.	
9 Other						
10 Total			158,802.		158,802.	

Part III **Bad Debt, Medicare, & Collection Practices**

Section A. Bad Debt Expense

			Yes	No
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	4,284,583.		
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	2,999,208.		
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	87,487,367.		
6 Enter Medicare allowable costs of care relating to payments on line 5	6	81,253,800.		
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	6,233,567.		
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 %
1	H.L. CANCER CTR	OUTPATIENT CANCER TREATMENT	50.00000		
2	HEART CTR OF GW	CARDIAC SERVICES MSO	50.00000		
3	SM INDEMNITY GROUP	INSURANCE COMPANY	100.00000		
4	FRANKLIN MEDICAL	PRIMARY CARE PHYSICIAN PRACT			100.00000
5	DIAGNOSTIC IMAGING	OUTPATIENT IMAGING CENTER	60.00000		
6	NAUGATUCK VALLEY MRI	MAGNETIC IMAGING	48.00000		52.00000
7					
8					
9					
10					
11					
12					
13					