BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 1: ASSET PURCHASE AGREEMENT

DRAFT NOVEMBER 13, 2014

ASSET PURCHASE AGREEMENT

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

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of Bristol Hospital, Inc. (the "**Hospital**"), Bristol Hospital Multispecialty Group, Inc. ("**BHMSG**"), Bristol Hospital EMS, LLC ("**EMS**"), and Bristol Health Care, Inc., including its subsidiary Ingraham Manor (the foregoing entities and the businesses operated by these entities, including the Hospital, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Bristol MSO, LLC (50%), Medworks, LLC (49%), Connecticut Occupational Medicine Partners, LLC (33%), Total Laundry Cooperative, LLC (14.1%), Central Connecticut Endoscopy Center, LLC (6.5%), and Connecticut Hospital Laboratory Network LLC (4.54%) (the foregoing entities are collectively referred to herein as the "**Joint Ventures**");

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

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

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

AGREEMENT:

1. DEFINITIONS AND REFERENCES

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

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program

receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise; *provided* that no stockholder of Tenet Healthcare shall be considered an Affiliate for the purposes of this Agreement;

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

(4) **Affirmative Election** is defined in Section 5.22(a);

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

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

(7) **Assumed Liabilities** means (i) the current liabilities included in Net Working Capital, but only to the extent accrued on the Closing Balance Sheets, (ii) all obligations of Seller arising under the Assumed Contracts with respect to periods (or portions thereof) following the Closing Date, (iii) all participating provider agreements and provider numbers with third party payors, including contracts and provider numbers of Government Payment Programs, to the extent the same are assignable to Buyer, (iv) all paid time off accruals of the Hired Employees (other than Extended Illness Bank Obligations) and estimated Taxes thereon, (v) the Extended Illness Bank Obligations, (vi) Permitted Encumbrances, (vii) any pension liability of Seller relating to its frozen defined benefit pension plan, (viii) any accrued post-retirement or other retirement obligation described on Schedule 2.03 and (ix) the other liabilities and obligations agreed to be assumed by Buyer, if any, described on Schedule 2.03;

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

(9) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Subsidiaries for the years ended September 30, 2011, 2012, and 2013, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and

the report thereon of Saslow Lufkin & Buggy, LLP, independent certified public accountants;

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

(11) **Buyer Deductible** is defined in Section 9.04(a);

(12) **Buyer's Indemnified Persons** means Buyer, VHS CT, Tenet Healthcare, Yale-New Haven Health Services Corporation, and their successors and assigns, together with their respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents and representatives;

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

(14) **CHEFA Bonds** means the tax-exempt bonds issued to Seller through the State of Connecticut Health and Educational Facilities Authority Revenue Bonds, Bristol Hospital Issue, Series B, with an issue date of January 8, 2002;

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

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

(17) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the close of business on the Closing Date, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

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

(19) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing, including the Local Board Bylaws and the Operating Agreement;

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

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

(22) **Community Foundation** means that certain community foundation designated by Seller in its sole discretion and approved by the Attorney General, which community foundation shall not be affiliated with Seller, shall be organized and operated exclusively for charitable purposes, exempt from federal tax under

section 501(c)(3) of the Code, and shall be publicly supported in accordance with section 170(b)(1)(A)(vi) of the Code (as modified by the accompanying Treasury Regulations);

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

(24) **Controlled Group** means with respect to Seller, a group consisting of each trade or business (whether or not incorporated) that, together with such Seller, would be deemed a "*single employer*" within the meaning of section 4001(a)(14) of ERISA;

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

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

(27) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with generally accepted accounting principles consistently applied;

(28) **Election Period** is defined in Section 5.22(a);

(29) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained or required to be sponsored or maintained by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in

control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

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

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

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

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

(34) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

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

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

(37) **Essential Services** means those hospital services described on Schedule 5.18;

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

(39) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing, including any line of credit to which Seller is a party, the CHEFA Bonds, any other indebtedness of Seller, any interest accrued as of the Closing Date on indebtedness of Seller, any settlements due as of Closing to third party payors, and all medical malpractice, general liability and workers' compensation claims that relate to any pre-Closing period;

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

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

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

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

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

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

(46) **Immaterial Contract** means any Contract to which Seller or any of the Hospital Businesses is a party that requires either the payment by Seller or any of the Hospital Businesses of $25,000 or less or the provision of goods or the performance of services by Seller or any of the Hospital Businesses having a value of $25,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Hospital Business without cause upon notice of ninety (90) days or less, the date on which the Contract would terminate if Seller or the respective Hospital Business were to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Hospital Business without cause upon notice of ninety (90) days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Sections 3.18(a) through 3.18(n);

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

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

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

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

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

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

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

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

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

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

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

(58) **Local Board** means the board of trustees for the Hospital, established pursuant to Section 5.17 below and the Local Board Bylaws;

(59) **Local Board Bylaws** means the bylaws or other governing document of the Hospital implemented as of the Closing Date and setting forth the rights and obligations of the Local Board, in substantially the form of Exhibit A attached hereto;

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

(61) **Material Adverse Change** means a material adverse change, individually or in the aggregate, on the business, assets, liabilities, financial condition, or results of operations of Seller and the Hospital Businesses taken as a whole, but excluding the effect of (i) matters described in the Schedules, (ii) changes in the economy of the United States in general or general economic or industry conditions generally applicable to hospitals or health care facilities within the United States or the State of Connecticut so long as such conditions do not disproportionately affect Seller and the Hospital Businesses, (iii) the announcement of the execution of this Agreement or the transactions contemplated hereby or the performance of any obligations hereunder, (iv) accounting changes required by generally accepted accounting principles, (v) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut, including changes or proposed changes to any state or federal law, reimbursements rates or policies of Governmental Authorities, if such change does not disproportionately affect Seller or the Hospital Businesses, or (vi) effects that are cured, or susceptible to cure without unreasonable effort, by Seller; provided that if the normalized earnings before interest, depreciation and amortization of the Hospital Businesses on a consolidated basis for the trailing 12-month period through the date of the most recent interim financial statements provided to Buyer pursuant to Section 5.04(b) (the "**Trailing EBITDA**") is not less than 80% of the normalized Trailing EBITDA for the preceding 12-month period, then a Material Adverse Change will not be deemed to have occurred (it being understood, however, that any facts, events, changes or developments causing or contributing to the failure of Seller's Trailing EBITDA to equal or exceed the normalized Trailing EBITDA for the preceding 12-month period may be taken into account in determining whether a Material Adverse Change has occurred).

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

(63) **Medical Waste** means any waste generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings, and (xi) any substance, pollutant, material or contaminant listed or regulated under the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.* or under the Medical Waste Law of any State;

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

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

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

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

in the Unaudited Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time but exclude Extended Illness Bank Obligations);

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

(69) **Offer** means a *bona fide* written offer pursuant to which a Person that is not an Affiliate of Buyer (other than Yale New-Haven Health Services Corporation ("**Yale**") or its Affiliates, provided that Yale or such Affiliate assumes the obligations of Buyer hereunder) would purchase, directly or indirectly, all or substantially all of the equity interests of the Hospital Businesses, or Assets of the Hospital Businesses that, in the aggregate, produce at least twenty-five percent (25%) of the total revenue of the Hospital Businesses, for the consideration and upon the other terms and conditions set forth in such offer. For the avoidance of doubt, (a) any corporate-level transactions involving Tenet Healthcare's stock or securities, including macro-level mergers, recapitalizations or reorganizations, (b) any sale of some or all of the Hospital Businesses (or Assets thereof) required by a Governmental Authority, and (c) any sale, merger or other transaction by Buyer or its Affiliates that does not relate solely or principally to the Hospital Businesses (or Assets related thereto) shall not be considered an Offer for purposes of this Agreement;

(70) **Operating Agreement** means the Operating Agreement of Buyer, in substantially the form of Exhibit B attached hereto;

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

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

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

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

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

(76) **Permitted Real Property Encumbrances** means (a) encumbrances for Taxes, assessments and other charges of Governmental Authorities not yet due and payable or being contested in good faith, (b) statutory liens incurred in the ordinary course of business for amounts not yet due and payable and not in

connection with any Seller default, (c) rights of tenants as tenants only, disclosed in the rent roll attached as Schedule 3.12(g); *provided*, that none of the foregoing do or will, individually or in the aggregate, materially impair the value or continued use and operation of the property to which they relate in the Hospital Businesses as presently conducted, and (d) those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

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

(78) **Principal Credit Agreement** means the Amended and Restated Credit Agreement, dated as of October 19, 2010 (as amended, modified, restated and supplemented from time to time), among Tenet Healthcare, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the other parties thereto, providing for the making of loans to, and the issuance of, and participation in, letters of credit for the account of the borrower thereunder, and any credit agreement or credit facility that replaces such Amended and Restated Credit Agreement;

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

(80) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(81) **Prohibited Transaction** is defined in Section 5.10;

(82) **Purchase Price** is defined in Section 2.05(a);

(83) **Purchase Price Adjustment** is defined in Section 2.05(e);

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

(85) **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(86) **Seller** means Bristol Hospital and Health Care Group, Inc., and includes as well all the Hospital Businesses unless the context clearly indicates otherwise.

(87) **Seller Deductible** is defined in Section 9.02(a);

(88) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Subsidiaries, Affiliates, successors and assigns, and their respective stockholders, members, partners, Subsidiaries, Affiliates, directors, trustees, officers, employees, agents and representatives;

(89) **Strategic Business Plan** means the five-year strategic and business plan, including the $45,000,000 capital spending plan developed in accordance with Section 5.20, collaboratively developed by Seller and Buyer that identifies the needs of Bristol, Connecticut and its surrounding communities with respect to institutional, physician, and ambulatory care services and the resources necessary to attain such needs, as the same may be amended from time to time in accordance with Section 5.30;

(90) **Subject Interest** is defined in Section 5.22(a);

(91) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with generally accepted accounting principles to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(92) **Target Net Working Capital** means $7,000,000;

(93) **Tax** means any income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(94) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code section 501(c)(3) organization required by a federal of state Governmental Authority, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(95) **Tenant Leases** is defined in Section 3.12(i);

(96) **Third Party Claim** is defined in Section 9.05(a)(i);

(97) **Title Representations** means the representations and warranties of Seller set forth in (i) the last sentence of Section 3.11 and (ii) the last sentence of Section 3.12(a);

(98) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*;

(99) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Subsidiaries as of [_____], 2014, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the [_____]-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b); and

(100) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq*.

1.02. Certain References. As used in this Agreement:

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships, joint ventures and limited liability companies;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Bristol, Connecticut time;

(i) references to "*Seller's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(a), after due inquiry by Seller of such Persons;

(j) references to "*Buyer's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(b), after due inquiry by Buyer of such Persons;

(k) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(l) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment of the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned or leased by Seller or used in the conduct of the Hospital Businesses; *provided* that any such leased personal property shall be described on Schedule 2.01(b);

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical/administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

(f) the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), the leases relating to the leased personal property listed or described on Schedule 2.01(b), and all Immaterial Contracts not listed or described on Schedule 2.02(j) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and the Information Systems;

(i) all property of Seller, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) the Investment interests in the Joint Ventures, including all transferable rights relating thereto;

(k) subject to Section 5.15, all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(l) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, but excluding the Proceedings described on Schedule 3.23 and any other such claims relating to Excluded Assets or the Excluded Liabilities;

(m) general intangibles of the Hospital Businesses, including goodwill;

(n) Seller's provider agreements with Government Payment Programs; and

(o) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Requirements or contractual requirements by which Seller is bound;

(b) all cash, bank accounts, certificates of deposit, treasury bills, treasury notes, marketable securities and other cash equivalents (including the Purchase Price payable to Seller) of Seller or the Hospital Businesses;

(c) all short-term and long-term Investments, except for the Investment interests in the Joint Ventures;

(d) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, malpractice self-

insurance fund, working capital trust assets, and assets and investments restricted as to use), donor restricted assets, beneficial interests in charitable trusts, trusts related to employee benefits, and any self-funded worker's compensation deposit of the Hospital Businesses, and accrued earnings on all of the foregoing;

(e) inventory and supplies disposed of or exhausted after the date of this Agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with Section 5.02(e);

(f) Cost Report settlement receivables and all appeals and appeal rights relating thereto;

(g) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture);

(h) all deductions, benefits, claims, refunds, receivables and other rights of Seller relating to Taxes in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this Agreement;

(i) all other current financial assets not included in Net Working Capital and all deferred expenses;

(j) all Immaterial Contracts that are listed or described on Schedule 2.02(j) and all other Contracts that are not Assumed Contracts (including this Agreement and the Closing Documents);

(k) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;

(l) the corporate or trade names set forth on Schedule 2.02(l) and all Intellectual Property rights relating thereto;

(m) all physician loans and receivables other than repayment obligations under Assumed Contracts;

(n) all right, title and interest of Bristol Hospital Development Foundation ("**BHDF**") in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(n);

(o) all insurance proceeds received by Seller or payable to Seller (i) with respect to the Excluded Assets or the Excluded Liabilities, or (ii) that Seller is entitled to retain pursuant to Section 5.15;

(p) the Proceedings described on Schedule 3.23, appeals and other risk settlements of the Hospital Businesses which arose during or relate to a pre-Closing period, and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

(q) all right, title and interest of Seller in the assets and properties (whether owned or leased) of the Parent and Child Program as currently operated by Seller (the "**Parent and Child Program**") and described on Schedule 2.02(q);

(r) any other assets identified on Schedule 2.02(q) or excluded after the execution of this Agreement by mutual written agreement of the parties; and

(s) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03.

2.04. Excluded Liabilities. Except for the Assumed Liabilities, Buyer shall not assume and under no circumstance will Buyer assume or be obligated to pay or assume, and from and after the Closing, none of the Assets will be or become liable for or subject to, any of the Excluded Liabilities, which Excluded Liabilities are and will remain liabilities of Seller, including the following:

(a) all liabilities accrued on the Closing Balance Sheets, to the extent (i) not included in Net Working Capital or (ii) relating to capitalized lease obligations constituting Assumed Contracts;

(b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date;

(c) liabilities or obligations for federal or state income Taxes of Seller or any Affiliate of Seller, including any amounts accrued or incurred by the Hospital Businesses in respect of periods ending on or before the Closing Date, as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;

(d) liabilities or obligations relating to the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract);

(f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or default on or before the Closing Date of any Assumed Contracts, and (iii) liabilities arising under any Contracts that are not Assumed Contracts;

(g) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 3.23, and Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that allegedly occurred on or before the Closing Date, including those relating to peer review activities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) except for (x) paid time off accruals of the Hired Employees and Extended Illness Bank Obligations, and (y) obligations under Assumed Contracts (including but not limited to Seller's frozen Employee Pension Benefit Plan), liabilities and obligations to Seller's employees, Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods before Closing (whether or not triggered by the transactions contemplated by this Agreement and whether or not imposed by Legal Requirements directly on Buyer as the transferee of the Assets or successor to the Hospital Businesses), including liabilities or obligations arising under any Employee Benefit Plan, EEOC claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller, including arising out of the operation of the Hospital Businesses or ownership of the Assets, with respect to periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this Agreement, including pursuant to third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services or the Connecticut Department of Social Services and recapture of previously reimbursed charges or expenses;

(l) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Requirement; and

(m) any and all liabilities or obligations relating to the Parent and Child Program described on Schedule 2.03(m).

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and tender the Purchase Price, determined as follows, subject to the adjustments described in Sections 2.05(b) and 2.05(e):

(i) $50,000,000, *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital.

(b) As further described in Sections 2.05(c) and 2.05(d) below, the Purchase Price will be calculated by Buyer and Seller at Closing from the physical count of inventory and supplies conducted pursuant to Section 2.05(c), if available, and the

relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available). At Closing, Buyer shall pay the Purchase Price less the book value of any capital leases (as of the Closing), pension liabilities of Seller relating to its frozen defined benefit pension plan (as determined by Buyer on a date within five (5) business days prior to the Closing), any accrued post-retirement or other retirement obligations (as determined by Buyer on a date within five (5) business days prior to the Closing) and other Assumed Liabilities (other than those included in Net Working Capital) and as adjusted by the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06, by wire transfer of immediately available funds to the accounts designated by the appropriate recipient as follows:

(i) To Seller, an amount equal to the sum of (A) the amount necessary to defease its outstanding CHEFA Bonds, (B) the amount necessary to repay its outstanding bank debt and satisfy the Indenture, (C) the value of Excluded Liabilities listed on Schedule 2.05(b), and (D) the indemnification reserve under Section 9.09; and

(ii) To the Community Foundation, the remaining balance of the Purchase Price, after the deductions set forth in Section 2.05(b) and after paying the amount due to Seller under subsection (i) above, and which amount received by the Community Foundation shall be used for the following purposes: (A) charitable health care consistent with the Hospital's historic charitable mission, (B) supporting or promoting health care generally in Bristol, Connecticut and its surrounding communities, or (C) with respect to donor restricted assets, a purpose consistent with the intent of the donor.

(c) The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five (5) business days before the Closing Date. Seller shall give Buyer at least five (5) business days prior notice of the date of the count and permit Buyer to monitor the count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, quality and quantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then

for purposes of the Closing, the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets.

(d) The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer. No more than five (5) business days before the Closing Date, Buyer and Seller will agree on the value as of Closing of the prepaid expenses and deposits that Buyer reasonably determines will be usable after Closing.

(e) Within ninety (90) days after the Closing Date, Buyer will deliver to Seller the Closing Balance Sheets together with any proposed revisions in the amount of the prorations to be made pursuant to Section 2.06 (based on paid invoices delivered by Buyer to Seller after the Closing). Except as otherwise provided herein, the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable and doubtful accounts, as used in preparing the Interim Closing Balance Sheets. The Purchase Price will be recalculated (based on clauses (i) and (ii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, and (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(d) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) on the Interim Closing Balance Sheets and on the Closing Balance Sheets. Following the resolution of any disputes pursuant to Section 2.05(f), Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Community Foundation (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five (5) business days after its determination.

(f) If Seller disputes any entry in the Closing Balance Sheets relevant to the calculation of the Purchase Price Adjustment or disputes the value of the inventory and supplies, and such dispute is not resolved to the mutual satisfaction of Seller and Buyer within ninety (90) days after the Closing Date, either Seller or Buyer may submit the dispute to Ernst & Young LLP or to such other independent, certified public accounting firm as Seller and Buyer may then agree in writing, in either case acting as experts and not as arbitrators to resolve the computation or verification of the disputed Closing Balance Sheets entries in accordance with this Agreement and otherwise where applicable in accordance with generally accepted accounting principles consistently applied.

(g) Seller and Buyer will each pay their own respective fees and expenses (including any fees and expenses of their accountants and other representatives) in connection with the resolution of disputes pursuant to this Section 2.05. Notwithstanding the foregoing, the fees and expenses of any accounting firm incurred in connection with the resolution of such disputes will be paid by Seller and Buyer in proportion to the

difference between the Purchase Price Adjustment determined by the accounting firm and the respective amounts of the Purchase Price Adjustment asserted by each such party at the time of the initial referral of the dispute to the accounting firm.

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property and with respect to any reduced amount of property Taxes (pursuant to any payment in lieu of taxes or similar agreement), such proration shall be calculated by giving credit to the Seller for any such reduced amount) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer promptly upon Buyer's receipt of such credit and Buyer agrees to promptly take all reasonable actions necessary in order to secure any such credit.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-profit corporation duly organized and validly existing in good standing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate and member action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of, any liabilities of Seller (other than Excluded Liabilities satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) do not violate any Legal Requirement to which Seller, the Assets, or the Hospital Businesses may be subject; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a material breach or violation of any material Contract to which Seller is a party or by which it is bound.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Subsidiaries and Third Party Rights. Seller has no Subsidiaries other than the Hospital Businesses, and Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its consolidated Subsidiaries, has total assets of $100,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of equity interests owned by Seller or its Affiliate in such Joint Venture and the name of, and percentage of equity interests owned by, third parties in such Joint Venture. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with or rights of any Person to acquire, directly or indirectly, any material assets, or any interest therein, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Tenet Healthcare or Buyer, or an Affiliate thereof, with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance. Seller and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material respects with, all Legal Requirements with respect to the operation of the Hospital Businesses and Seller has timely filed all material reports, data and other information required to be filed with Governmental Authorities or has requested appropriate extensions of such filing deadlines. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor any Subsidiary of Seller is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of the Hospital Businesses in all material respects as of the respective dates thereof and for the periods therein referred to, all in accordance with generally accepted accounting principles, subject, in the case of the Unaudited

Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements to Seller's knowledge, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by generally accepted accounting principles to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, and none of which could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.08. Recent Activities. Since December 31, 2013, and except as set forth on Schedule 3.08:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of business of the Hospital Businesses in accordance with their existing personnel policies, Seller has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses, or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute and, to Seller's knowledge, no enactment or promulgation of a state or local Legal Requirement or other event or condition, has occurred that has materially adversely affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and Seller has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of $75,000, with a comparable replacement thereof;

(e) no Encumbrance has been imposed on any of the Assets other than Permitted Encumbrances;

(f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of Seller or its Affiliates, or with any Affiliate of any such Person;

(i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Requirement;

(j) Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in *bona fide* commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable. Since December 31, 2013, Seller has not sold any Accounts Receivable, including Accounts Receivable that have been written off or fully reserved.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Schedule 3.10 includes a depreciation schedule as of a recent date that lists all major items of equipment associated with, or constituting any part of, the Assets. All such major items of equipment are useable for their intended purposes in the ordinary course of the Hospital Businesses and are in working condition, subject to reasonable wear and tear. All medical and leased equipment has been maintained in all material respects in accordance with manufacturer and lessor requirements, and equipment maintenance logs or journals have been maintained in all material respects in compliance with required accreditation standards.

3.11. Title. Except as provided in Schedule 3.11 and subject to Section 10.03, Seller owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11 and Permitted Encumbrances. At Closing, Seller will convey to Buyer good and valid title to all Assets, free and clear of any Encumbrances other than the Permitted Encumbrances.

3.12. Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a) and Permitted Encumbrances. The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller or any Subsidiary of Seller that is associated with or employed in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and indefeasible fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) Seller has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) To Seller's knowledge, the buildings standing on the Owned Real Property are structurally sound, and in need of no material maintenance or repairs except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. No part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) To Seller's knowledge, except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.17, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise. No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the

future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all Permits and requisite certificates of the local board of fire underwriters (or other body exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) (i) Seller has provided to Buyer accurate and complete copies of those leases of which Seller or one of its Subsidiaries is landlord (collectively, the "**Space Leases**"), and (ii) attached to Schedule 3.12(g) is a "rent roll" that sets forth the following information for each of the Space Leases: (A) the names of the current tenants; (B) the rental payments for the then current month under each of the Space Leases; (C) a list of all then delinquent rental payments; (D) a list of all concessions granted to tenants; (E) a list of all tenant deposits and a description of any application thereof; (F) the dates that each of the Space Leases commenced and will expire; (G) the square footage of any such space leased pursuant to the Space Leases; (H) any renewal options available to tenants under the Space Leases; and (I) a list of all uncured material defaults under the Space Leases known to Seller.

(h) There are no tenants or other persons or entities occupying any space in the Owned Real Property, other than pursuant to the Space Leases.

(i) Seller has (i) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a) pursuant to the leases described on Schedule 2.01(b) (the "**Tenant Leases**"), and (ii) provided accurate and complete copies of each of the Tenant Leases. The Leased Real Property comprises all of the real property leased by Seller or any Subsidiary of Seller that is associated with or employed in the operation of the Hospital Businesses.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all Permits required under applicable Environmental Laws, and all such Permits are listed on Schedule 2.01(g). No Environmental Claim is pending or to Seller's knowledge threatened by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where Seller stores, disposes or arranges for the disposal of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.13(b), (iv) no asbestos is contained in or forms part of any building, building component, structure or office space owned or leased by Seller and used in the conduct of the Hospital Businesses, and (v) no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations or Encumbrances, and, to Seller's knowledge, claims of infringement, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any written notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in Section 3.18(c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). Seller has provided to Buyer a true and complete copy of all such policies and endorsements thereto. With respect to third party insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. All of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since December 31, 2009, Seller has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage provided thereby. Since December 31, 2009, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and, to Seller's knowledge, not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. The Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately licensed are duly licensed by the appropriate Governmental Authorities and comply in all material respects with the applicable licensing requirements. The Hospital Businesses have complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.17. Government Payment Programs; Accreditation. The Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. The Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through December 31, 2013, and Cost Reports **[covering periods prior to _____]** have been audited and notices of program reimbursement have been issued for all Cost Report periods through December 31, 2009. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of Seller under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, to Seller's knowledge, Seller has not received or submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or the Hospital's participation therein that remains outstanding or unresolved, except as set forth on Schedule 3.17. All Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by Seller under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Seller or its Affiliates and no such incentive payments were remitted due to any fraudulent, negligent or unlawful act or omission of Seller or its Affiliates. Seller has 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**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made in substantially the form and manner required by CMS and The Joint Commission, respectively. Seller has 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. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded

prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. The Hospital is duly accredited, with no contingencies, by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to the Hospital has been made available to Buyer. Seller has delivered to Buyer copies of the most recent accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein.

3.18. Agreements and Commitments. Schedule 3.18 identifies and sets forth certain information regarding Contracts related to the Hospital Businesses in the categories below:

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

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospital, or (iii) any Person that provides marketing services for Seller;

(c) Contracts relating to Intellectual Properties and Information Systems;

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

(e) Contracts with directors, trustees, officers, employees, or other agents of Seller;

(f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;

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

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between Seller and any of the Joint Ventures;

(j) Contracts with municipalities;

(k) Contracts providing for payments based in any manner on the revenue or profits of the Hospital Businesses or the Assets;

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

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

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

3.19. Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f), except as disclosed on Schedule 3.19:

(a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and are enforceable against Seller in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement by and between the parties thereto, unless otherwise noted therein;

(c) all material obligations required to be performed under the Assumed Contracts by Seller, and, to Seller's knowledge, each other party thereto, on or before the date of this Agreement have been performed, and no event has occurred or failed to occur that constitutes, or with the giving of notice, the lapse of time or both would constitute, a material default by Seller under the Assumed Contracts;

(d) no Assumed Contract contains an express prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing; and

(e) subject to obtaining any consents from third parties to any applicable Assumed Contract, the assignment of any Assumed Contract to and assumption of such Assumed Contract by Buyer will not give a third party the right to terminate such Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Except as set forth on Schedule 3.20, since December 31, 2013, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller except as set forth in Schedule 3.20 or upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii)

a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates working at the Hospital Businesses (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) All employees, former employees and independent contractors of Seller 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 Legal Requirement, except in each case where a failure to be so classified would not have an adverse effect on the business, assets, liabilities, financial condition, or results of operations of the Hospital Businesses.

(c) Except as set forth in Schedule 3.21(c), Seller has complied in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; Seller is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.21(d) states the number of employees terminated by Seller within ninety (90) days prior to the Closing Date, laid off by Seller within the six (6) months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Seller 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. In relation to the foregoing, except as set forth in Schedule 3.21(d), Seller has not violated the WARN Act or any similar state or local Legal Requirement.

(e) Schedule 3.21(e) identifies those employees whose primary responsibility is to the Parent and Child Program, whose employment will be terminated and transitioned by Seller to a successor non-profit entity prior to Closing, in accordance with Section 5.31.

(f) To the knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller is bound by any contract that purports to

limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of Seller in respect of the Hospital Businesses or the Assets; or (ii) to assign to Seller any rights to any invention, improvement, or discovery. To the knowledge of Seller, no former or current employee of Seller is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as Seller did prior to Closing.

(g) No employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to Seller's knowledge, threatened. No employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place. No complaint, charge or claim is pending or, to Seller's knowledge, threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(h) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To Seller's knowledge, no employee of Seller who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and Seller has complied with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To Seller's knowledge, Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and, where required by law, re-verified all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with federal immigration regulations, including compliance with federal immigration laws. Seller has 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 Seller has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of Seller. If Seller operates in a state or has contracts with a Governmental Authority that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, Seller has been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as Seller has been operating in such state or contracting with such Governmental Authority.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any of its Subsidiaries that are members of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals) (each, a "**Current Seller Plan**"). Except for the Current Seller Plans, Seller has no liability with respect to any Employee Benefit Plan of a member of the Controlled Group that includes Seller.

(b) Each Current Seller Plan, and related trust, insurance contract or fund, complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current Seller Plan and applicable Legal Requirements. With respect to each Current Seller Plan, all required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan, or Seller has requested appropriate extensions of such filing deadlines. Seller has delivered to Buyer, to the extent applicable: copies of the currently effective plan documents and currently effective summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller has maintained, or to which it has contributed or been required to contribute (each, a "**Prior Seller Plan**"), during the five (5) years preceding the date of this Agreement, and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) required to be made by Seller or its Subsidiaries to each Current Seller Plan that is an Employee Pension Benefit Plan that are required to be paid have been paid. To Seller's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal Revenue Service, as applicable. To Seller's knowledge, nothing has occurred with respect to any Current Seller Plan that has subjected or could reasonably be expected to subject Seller, or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a penalty under section 502 of ERISA or to an excise tax under the Code. To Seller's knowledge, with respect to any Current Seller Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject the Seller or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a tax under section 4971 of the Code or the assets of any of the foregoing persons to a lien under section 412(n) of the Code.

(d) Except as provided on Schedule 3.22(d), the requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments for all periods ending on or before the Closing Date for which the payment deadline has expired have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any liability. To the extent that the Seller, any of its Subsidiaries or any employee thereof is considered an ERISA Fiduciary with respect to any Current Seller Plan or Prior Seller Plan, no such ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or, to Seller's knowledge, threatened and, to Seller's knowledge, there exists no basis for any such Proceeding. No "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Benefit Pension Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.22(f), no Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or, to Seller's knowledge, the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or to Seller's knowledge threatened. Seller has not incurred, and, to Seller's knowledge, no event has occurred prior to the date hereof that will cause Seller to incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) Neither Seller nor any member of a Controlled Group that includes Seller contributes to, has contributed to, or has been required to contribute to, during the six (6) calendar years preceding Closing, any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan.

3.23. Proceedings and Claims. Schedule 3.23 contains a list and summary description of each Proceeding and claim (including *qui tam* Proceedings and claims) pending or, to Seller's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, Seller or any Affiliate of Seller (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or claim). All such Proceedings and claims are or, to Seller's knowledge, will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. To Seller's knowledge, none of the Proceedings or claims described on Schedule 3.23, if determined adverse

to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Seller has filed all Tax Returns required to be filed by or on behalf of Seller on or prior to the date of this Agreement, all such Tax Returns are accurate in all material respects, and Seller has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of Seller, threatened. There are no outstanding agreements by Seller for the extension of time for the assessment of any Taxes.

(d) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has ever been made by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction and no Encumbrances have arisen against Seller or the Assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to Seller.

(f) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of Seller and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service regarding such Tax status and, to Seller's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption.

(h) Neither Seller nor any Affiliate of Seller has any liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations. Seller has delivered to Buyer a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of the Hospital. Seller has also delivered to Buyer a list, current as of the date of this Agreement, that sets forth (i) the name and age of each member of the medical staff of the Hospital (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 of the Hospital, (iii) the names of the medical staff members (current and former) of the Hospital in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three (3) years, and (iv) the number of current medical staff members of the Hospital in respect of 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. No material disputes between Seller and any medical staff member of the Hospital are pending or, to Seller's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. To Seller's knowledge, no member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any liability in respect of funds received by any Person for the purchase, improvement or use of any of the Assets or the conduct of the Hospital Businesses under restricted or conditioned grants or donations, including monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Except for Cain Brothers & Company, LLC, neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. To Seller's knowledge, none of the Hospital Businesses has made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor any officer, director or trustee of Seller has received or will receive as a result of the consummation of the transaction contemplated by this Agreement any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Hospital Businesses and Joint Ventures.

(a) Each of Seller's Subsidiaries (except for EMS) is a corporation duly organized under the laws of the State of Connecticut with full corporate power to carry

on its business as it is now being conducted. Each of Seller's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock or other equity interests of Seller's Subsidiaries (except EMS) are owned as specified on Schedule 3.30(a). All of the issued and outstanding shares of capital stock or other equity interests of Seller's Subsidiaries have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of Seller's Subsidiaries and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of Seller's Subsidiaries and has provided to Buyer a copy of, or access to, the minute books of Seller's Subsidiaries.

(b) EMS is a limited liability company duly organized under the laws of the State of Connecticut with full limited liability company power to carry on its business as it is now being conducted. EMS is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of its assets or properties, or the conduct or nature of its businesses, makes such licensing, qualification or admission necessary. All of the membership interests of EMS are owned as specified on Schedule 3.30(a). All of the outstanding membership interests of EMS have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any membership interests of EMS and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of organization and operating agreement and other agreements, instruments and documents relating to the creation, ownership and governance of EMS and has provided to Buyer a copy of, or access to, the minute books of EMS.

(c) Each Joint Venture is a limited liability company organized under the laws of the State of Connecticut with full limited liability company power to carry on its respective business as it is now being conducted. Each of the Joint Ventures is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. Except as set forth in the operating agreements of the Joint Ventures, the transfers to Buyer of the membership interests in the Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer a copy of the articles of organization and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the Joint Ventures, and has provided to Buyer a copy of, or access to, the minute books of the Joint Ventures, to the extent within Seller's possession or control.

3.31. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all material assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in the manner in which they have been operated since December 31, 2011, except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.31 sets forth a list of the ten (10) largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the year ended December 31, 2013. Since December 31, 2013, no payor listed on Schedule 3.31 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

3.32. Full Disclosure. The representations of Seller 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. Seller has provided or made available to Buyer all material documents and information that has been requested by Buyer or its representatives.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization. Buyer is a limited liability company duly organized and validly existing and in good standing under the laws of the State of Delaware. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing.

4.02. Power and Authority; Due Authorization. Buyer has full power and authority to (a) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (b) perform its obligations under this Agreement and such Closing Documents and (c) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary limited liability company action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which Buyer is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within Buyer's limited liability company powers, are not in contravention of its certificate of formation, company agreement or other governing

documents, and have been duly approved by all required limited liability company and member action;

(b) do not violate any Legal Requirement to which Buyer is subject; and

(c) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which Buyer is a party or by which it is bound.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer is or becomes a party are (or, upon execution and delivery thereof by Buyer at the Closing, will be), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the respective terms hereof and thereof.

4.05. Governmental Consents. Buyer is not aware of any consent, approval, license or other authorization from any Governmental Authority that it will not obtain prior to Closing, which failure to obtain would prevent the consummation of the transactions contemplated by this Agreement.

4.06. Proceedings and Compliance. There are no claims, actions, suits, proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder, or (e) except as disclosed in Tenet Healthcare's publicly available filings with the Securities and Exchange Commission, could reasonably be expected to result, individually or in the aggregate, in a material adverse change in the business, financial condition, or results of operations of Buyer or its Affiliates. In addition, Buyer and its Affiliates are in compliance with all Legal Requirements with respect to the operation of their businesses, except where the failure to be in compliance would not have a material adverse effect on the conduct of their businesses, taken as a whole, or on the transactions contemplated by this Agreement.

4.07. Government Programs.

(a) There is no existing Corporate Integrity Agreement and/or Settlement Agreement in effect between Buyer or any Affiliate or Subsidiary of Buyer and any Governmental Authority.

(b) Neither Buyer nor any Affiliate or Subsidiary of Buyer is aware of any material matter that could have a material adverse effect on the transactions contemplated by this Agreement or the operation of the Hospital Businesses by Buyer after Closing.

4.08. Availability of Funds. Buyer has the ability to obtain funds in cash in amounts equal to the Purchase Price and necessary to perform its obligations hereunder that are to be

performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform its obligations hereunder that are required to be performed as of Closing.

4.09. Solvency. Neither Buyer nor any Affiliate of Buyer has any intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Buyer's or any Affiliate of Buyer's property and no other Person has filed or, to Buyer's knowledge, threatened to file such a petition against Buyer or any Affiliate of Buyer. Neither Buyer nor any Affiliate of Buyer will be rendered insolvent as a result of any of the transactions contemplated by this Agreement.

4.10. Brokers and Finders. Neither Buyer nor any Affiliate of Buyer, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.11. Full Disclosure. The representations of Buyer in this Agreement and the Schedules do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading. Buyer has provided or made available to Seller all material documents and information that has been requested by Seller or its representatives.

5. COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates to:

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses;

(b) use good faith efforts to maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that Seller shall consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) that exceed $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual capital or operating budgets that have been provided to Buyer;

(c) perform in all material respects, when due, all Legal Requirements and obligations under Contracts;

(d) maintain title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances);

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) use good faith efforts to (i) maintain and preserve its business organizations and operations intact, (ii) retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course of the Hospital Businesses), and (iii) maintain its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses in the ordinary course of the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate to:

(a) amend or terminate any Assumed Contract, or enter into any Contract except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall obtain Buyer's consent on any new Contract (or a series of related Contracts) that has required payments by Seller that exceed $250,000, unless such Contract may be terminated without cause upon no more than ninety (90) days written notice and such termination will not result in any penalty or fee;

(b) enter into any tertiary affiliation other than the Yale Network Member Agreement, a copy of which Seller has provided to Buyer;

(c) increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets other than Permitted Encumbrances;

(e) sell or otherwise transfer or dispose of any material item of property, plant, equipment or other Asset except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof;

(f) distribute any assets other than Excluded Assets, to any Affiliate of Seller that is not one of the Hospital Businesses;

(g) make any capital expenditure in excess of $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual operating or capital budgets that have been provided to Buyer;

(h) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses, 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;

(i) create, incur, assume, guarantee or otherwise become liable for any liability or obligation in excess of $250,000, or agree to do any of the foregoing;

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

(k) amend, change or modify the title or duties of the chief executive officer of Seller;

(l) sell or factor any Accounts Receivable;

(m) change any accounting method, 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 generally accepted accounting principles or applicable Legal Requirements;

(n) terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for amendments required to comply with this Agreement or applicable Legal Requirements;

(o) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of any of the Hospital Businesses or otherwise take any action relating to any liquidation or dissolution of Seller, except as expressly contemplated by this Agreement;

(p) amend or agree to amend the governing documents of any Joint Venture, except immaterial amendments or amendments required to comply with applicable Legal Requirements or to assign and transfer to Buyer Seller's Investment in, or for Buyer to become a partner or member or shareholder of, such Joint Venture; or

(q) take any action outside the ordinary course of the Hospital Businesses.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this Section and in Section 5.31and in reliance upon the representations of Seller in Sections 3.21 and 3.22, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date all active employees of Seller who work at the Hospital Businesses (other than in primary support of the Parent and Child Program) and are in good standing immediately before Closing, and all employees of Seller who are as of the Closing Date on approved leave, including those workers then eligible for and receiving disability, or workers' compensation; provided, that the hire date for any employees on approved leave would be such date as the employee is eligible to return to work. Each such offer shall be on the same terms and conditions with respect to job duties, titles, locations and responsibilities that are applicable to such employees on the date of this Agreement. Buyer shall not reduce the

base salaries or wages of the Hired Employees for a period of 12 months after Closing. In addition, Buyer will offer or cause its Affiliates to offer the Hired Employees Employee Benefit Plans consistent with Employee Benefit Plans offered to employees at other hospitals operated by Subsidiaries of Tenet Healthcare in other markets.

(b) Seller acknowledges that, other than employment agreements with physicians which shall be assumed by Buyer or one of Buyer's Affiliates at Closing in accordance with subsection (g) below, all employment offers are for "at will" employment only and are subject to the satisfactory completion by Buyer of Tenet Healthcare's customary employee background checks and pre-employment screenings. Nothing in this Section or elsewhere in this Agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in Section 5.03(a), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, provided that Buyer will assume and honor all severance agreements between Seller and Seller's employees existing as of Closing.

(c) With respect to the Hired Employees and their eligible dependents, Buyer will waive any "pre-existing condition" exclusions in Buyer's paid time-off and Employee Welfare Benefit Plans, to the same extent such exclusions were waived in Seller's Employee Welfare Benefit Plans as of the Closing Date. Buyer will give all Hired Employees credit for their vacation, holiday and sick pay (whether in such form or in the forms of so-called "paid time off" or an "extended illness bank") to the extent the same constitute Assumed Liabilities as set forth on Schedule 2.03. Buyer shall give all Hired Employees credit after Closing for their years of service with Seller for the purpose of determining how much vacation, holiday and sick pay the Hired Employees are entitled to under Buyer's Employee Welfare Benefit Plans and for purposes of determining eligibility to participate and vesting percentages in Buyer's Employee Pension Benefit Plans to the same extent such service was recognized under Seller's Employee Pension Benefit Plans as of the Closing Date. Buyer will not assume or otherwise become liable for, and Seller will remain solely responsible for (i) Seller's Employee Welfare Plans, (ii) long term disability payments to any former employee of Seller who does not actively work for Buyer after Closing, and (iii) any other obligations to former or currently retired employees or their dependents. Buyer will make available group health plan continuation coverage required under COBRA to employees and former employees of Seller and current or former dependents thereof who are eligible for COBRA ("**Seller's COBRA Beneficiaries**"), provided that, with respect to Seller's COBRA Beneficiaries whose qualifying events occurred on or prior to the Closing Date, Seller will reimburse Buyer for all claims of such Seller's COBRA Beneficiaries paid by Buyer and its Affiliates in excess of the sum of (A) COBRA premiums collected from Seller's COBRA Beneficiaries; and (B) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all such Seller's COBRA Beneficiaries. Buyer (or its designated agent) shall timely and properly file all claims incurred by Seller's COBRA Beneficiaries with Buyer's stop loss carrier, and that Seller shall not be liable for any claims of Seller's COBRA Beneficiaries that would have been

reimbursed by Buyer's stop loss carrier if such claim had been timely and properly filed by Buyer or its agent.

(d) As of the Closing, Buyer agrees to assume the assets and liabilities of, and administer, Seller's frozen Employee Pension Benefit Plan known as the "Bristol Hospital & Health Care Group Retirement Plan" and assume all collective bargaining agreements of Seller that pertain to the Hospital Businesses.

(e) Between the date of this Agreement and Closing, Buyer or one of its Affiliates, with the prior written approval of Seller, may run newspaper advertisements or post similar other notices, in the name of any of the Hospital Businesses or in the name of Buyer or one of its Affiliates, to recruit employees for the Hospital Businesses to commence on or after the Closing Date.

(f) At Closing, Seller shall deliver to Buyer a list setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this Agreement and the Closing Date.

(g) This Section shall not apply to employees employed by Seller under Assumed Contracts. Employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(h) Prior to Closing, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after Closing, Buyer will be responsible for compliance by Buyer with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

(i) Seller and its Affiliates shall remain solely responsible, and Buyer shall have no obligations whatsoever, for the Seller's Employee Pension Benefit Plans known as the Bristol Hospital Multi-Specialty Group, Inc. 401(k) Plan and the Bristol Hospital & Health Care Group 403(b) Tax Sheltered Annuity Program, and the distribution of benefits from those plans.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets and books and records relating to the Hospital Businesses, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to

Seller. Buyer shall exercise its rights under this Section 5.04(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses. Buyer agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Buyer without Buyer first providing reasonable notice to Seller and coordinating such inspection or contact with Seller.

(b) Seller will deliver to Buyer:

(i) within twenty-five (25) days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within forty (40) days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) Until the Closing Date, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any personal health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by The Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Due Diligence; Disclaimer.

(a) Buyer acknowledges and agrees that prior to the date of this Agreement, it was afforded the opportunity to conduct all investigations, inspections, interviews, reviews and analysis and other due diligence with respect to the Hospital Businesses and the Assets, including any relating to the financial physical, structural, mechanical, electrical, environmental and other condition or aspect of the Hospital Businesses, title to the Properties, compliance of the Properties with work orders and zoning, fire and other building requirements, and the Transaction, which the Buyer deemed necessary or desirable (the "**Due Diligence**"), and that such Due Diligence has been completed to Buyer's reasonable satisfaction.

(b) Disclaimer. Buyer acknowledges and agrees that, except as set forth in this Agreement and the Closing Documents, and subject to the representations and warranties herein and therein, the Assets and the Hospital Businesses and all assignments and other aspects of the transactions contemplated herein are being sold and purchased or otherwise dealt with on an "as-is, where-is" basis with respect to their physical condition.

5.06. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five (5) years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies. For purposes of this Agreement, the term "records" includes all documents, electronic data, and other compilations of information in any form. Buyer acknowledges that as a result of entering into this Agreement and operating the Hospital Businesses it will gain access to patient and other information that is subject to state, federal and Seller's own internal rules and regulations regarding confidentiality. Buyer agrees to abide by all applicable laws relating to the confidential information it acquires. Buyer agrees to maintain the patient records delivered to Buyer at the Closing at the Hospital Businesses after Closing to the extent required under applicable law (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. §1395(v)(1)(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 Seller and upon the Buyer's receipt of appropriate consents and authorizations, the Buyer will afford to the representatives of Seller, including its counsel and accountants, reasonable access to, and copies of, the records transferred to Buyer at the Closing (including access to patient records in respect of patients treated by Seller at the Hospital Businesses for any reasonable purpose, to the extent permitted by law). In addition, to facilitate the foregoing purposes, each party shall also make such books, records,

documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed from the Hospital Businesses to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) For seven (7) years after the Closing Date, Seller will give Buyer, within thirty (30) days after request, an updated claims history, including losses paid and open reserves, for all professional liability, general liability and workers compensation claims relating to the conduct of the Hospital Businesses on or before the Closing Date.

5.07. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authorities to consummate the transactions contemplated by this Agreement, *provided* that no party may be required (x) to pay any sum to Governmental Authorities other than filing fees or past due amounts, or (y) to agree to divest assets or limit the conduct of its businesses.

(b) Until the Closing Date, each party shall provide all reports and other documents required or requested by Governmental Authorities under Legal Requirements concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the preceding sentence and shall exchange drafts of the relevant portions of each other's report forms before filing.

(c) Seller shall pay all regulatory filing fees for, and other fees incurred in connection with, licenses, certificates, permits, consents, approvals, authorizations and clearances of Governmental Agencies as may be required for the parties to consummate the transactions contemplated by this Agreement, except for the fees that Buyer is required to pay under Connecticut law.

(d) Seller shall promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, *provided* that no such efforts shall require the expenditure of a material sum of money, incurring of concessions, or initiation of litigation.

(e) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a Contract that supersedes or replaces an existing Contract between Seller and a third party. Such new Contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement Contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such Contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such Contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement Contract did not exist or such assumption of Excluded Liabilities was not required.

5.08. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed one hundred twenty (120) days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses; *provided* that Buyer shall indemnify Seller and its Affiliates in connection with Buyer's use thereof, as set forth in Section 9.03 below. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in

the form of Exhibit C hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications.

5.09. Connecticut Transfer Act. This transaction may be subject to the Transfer Act. Accordingly, if required by Legal Requirements, Seller shall prepare a Transfer Act Form III and the accompanying Environmental Condition Assessment Form ("**ECAF**") for the Hospital Businesses to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Copies of the Form III and the ECAF will be provided to Buyer at least 30 days prior to the Closing Date so that Buyer may review and provide reasonable comments. Seller shall sign the Form III as the "Transferor" and Seller or its designee shall sign the Form III as the "Certifying Party" responsible for completing all the required environmental investigation and remediation at the Hospital Businesses in accordance with the Transfer Act, the Connecticut Remediation Standard Regulations, and other applicable Environmental Laws. Buyer shall sign the Form III as the "Transferee." Seller shall furnish copies of the Form III and the ECAF to Buyer prior to the Closing Date for Buyer's execution. Within ten days after the Closing Date, Seller shall (i) file the fully executed Form III and the ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEP**"); (ii) pay the initial $3,000 filing fee and any subsequent Transfer Act fees; and (iii) provide written confirmation to Buyer that the Transfer Act filing has been completed (with a copy of such filing). Seller or its designee shall conduct and complete any actions required by the CTDEP as a result of the filing of the Form III and the ECAF, as necessary to comply with the requirements of the Transfer Act to obtain written confirmation from CTDEP or a "verification" from a "Licensed Environmental Professional" that the Hospital Businesses have been remediated in full compliance with the Connecticut Remediation Standard Regulations. All undefined terms in this Section 5.09 shall have the meanings set forth in the Transfer Act.

5.10. No-Shop Clause. Until the Closing or earlier termination of this Agreement in accordance with its terms, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or otherwise dispose of all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this Section.

5.11. Noncompetition. For a period of five (5) years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses, including any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, wellness center, urgent care center, ambulatory service, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a thirty (30) mile radius of the Hospital (the "**Restricted Area**"); (ii) employ or solicit the employment of any Hired Employee unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliate after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any Contract for the provision or arrangement of health care services from the Hospital Businesses with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any Contract with or change practice patterns at the Hospital Businesses. Notwithstanding the foregoing, however, Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospital: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services, social welfare, and other non-medical services for women, infants and children or parent/child services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services to be provided by Buyer. In the event of a breach of this Section, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Buyer and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

5.12. Change of Corporate Names. From and after Closing, except as set forth on Schedule 5.12, Seller shall not use the names "*Bristol Hospital*," "*Bristol Hospital Multispecialty Group*," "*Bristol Health Care*," "*Bristol Health*" or any variation of the foregoing or any other

Intellectual Property included in the Assets, except as may be necessary to wind up its corporate affairs and make filings (including Tax Returns) required by Legal Requirements. Notwithstanding the foregoing, Seller may continue to use the name "Bristol Hospital Development Foundation" until such time as the governing board of BHDF determines a new name for such foundation.

5.13. Allocation of Purchase Price. Within one hundred twenty (120) days after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties sixty (60) days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within sixty (60) days after Seller gives its objection to Buyer. If a final resolution is not reached within sixty (60) days after Seller has submitted its objection in writing, Buyer and Seller shall utilize the dispute mechanism described in Section 2.05(f), and the determination of an independent, certified public accounting firm as Seller and Buyer may then agree in writing (such accounting firm entitled to engage any third party valuation experts as necessary in order to determine such allocation) shall be binding on the parties hereto. The Buyer and Seller 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. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the Internal Revenue Service in accordance with such allocation.

5.14. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can reasonably execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands after the Closing that relate to or constitute a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

5.15. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof

any material part of such Hospital Businesses 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 8.04, (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 Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds (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 Seller and Buyer will determine any reduction in Purchase Price pursuant to such clause (ii). If Buyer fails to make a timely election pursuant to this Section, Buyer shall be deemed to have made the election described in clause (iii) above.

5.16. Seller's Cost Reports. Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this Agreement. Buyer will provide information to Seller and assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in Section 5.13. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within ten (10) business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any amounts receivable or payable in respect of such reports, refunds or reserves relating to the Cost Reports, and the right to appeal any Medicare determinations relating to the Cost Reports.

5.17. Governance Matters.

(a) Buyer shall cause the Local Board Bylaws, in substantially the form attached as Exhibit A hereto, to be adopted and effective as of the Closing Date. Pursuant to the Local Board Bylaws, as of the Closing, there shall be established a ten (10) member Board of Trustees for the Hospital, which shall be comprised of four (4) physicians members of the Hospital Medical Staff, five (5) community leaders selected from among members of Seller's current Board of Directors, including the current Board Chair (the "**Initial Community Directors**"), and the chief executive officer of the Hospital. All members of the Board of Trustees shall be voting members. A majority of members of the Board of Trustees shall not be members of the Medical Staff. The Elect Chief of Staff, newly appointed Board of Trustee members (but whose term has not commenced), Chief Operating Officer, Chief Nursing Officer, Chief Financial Officer, the Hospital and Company Regional Chief Medical Officer(s), the Vice President of Medical Affairs, Company Regional Counsel and the Company Regional Senior Vice

President may attend all Board of Trustee meetings but shall not have a vote. The only members of the Medical Executive Committee who may also be members of the Board of Trustees are the President/Chief and Elect Chief of Staff of the Medical Staff of the Hospital who may serve as ex-officio, non-voting members. The members of the initial Local Board are set forth on Schedule 5.17 hereto. For the Initial Five Year Period (defined in Section 5.21 below), the Initial Community Directors (and their successors), together with a Buyer appointee, shall serve as the nominating committee to nominate candidates to fill expired or vacant Initial Community Director positions on the Local Board. Such nominating committee shall act by majority vote of its members.

(b) Pursuant to the Local Board Bylaws (and as more fully described therein), the Local Board shall be responsible for and make recommendations to Buyer and its Board of Directors regarding the establishment of Hospital policies, the maintenance of patient care quality, and the provision of clinical service and community service planning in a manner responsive to community needs. Buyer agrees that reasonable recommendations of the Local Board will be considered in good faith by the Buyer's Board of Directors. During the Initial Five Year Period, Buyer will obtain approval of the Local Board for any amendment to the Local Board Bylaws that would affect the structure, membership, duties, or authority of the Local Board or change powers reserved to the Local Board, other than amendments that are made to comply with applicable Legal Requirements, governmental guidelines or policies or requirements of accreditation agencies.

(c) As of the Closing, Buyer will hire the current chief executive officer of Seller and the Hospital, and assume his existing employment agreement. During the Initial Five Year Period, (i) Buyer will consult with the Local Board before hiring any successor chief executive officer of the Hospital, and (ii) to the extent consistent with the powers generally delegated to chief executive officers of Tenet Healthcare-affiliated hospitals, Buyer will delegate to the Hospital's chief executive officer the authority to hire/fire the Hospital's management team.

5.18. Preservation of Essential Services and Quality Care. For at least ten (10) years after Closing, Buyer will cause the Hospital Businesses to provide the Essential Services described on Schedule 5.18 in the manner deemed necessary or appropriate in the discretion of the Local Board. During all periods that Buyer, or a Buyer Affiliate or Buyer Subsidiary, controls and operates the Hospital Businesses, Buyer agrees to maintain or enhance Seller's historic commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs, and shall strive to ensure that the Hospital Businesses meet identified targets and goals with respect to regulatory, quality and safety targets and patient experience measures.

5.19. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines

or policies, during all times that Buyer or a Buyer Affiliate or Buyer Subsidiary owns and operates the Hospital Businesses, Buyer will ensure that the Hospital Businesses maintain and adhere to Seller's current policies on charity care, indigent care and community benefit attached as Schedule 5.19 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as Seller's existing policies. For the Initial Five Year Period, Buyer shall consult with the Local Board with respect to any proposed changes in such policies and procedures, other than changes in such policies and procedures that are made to comply with applicable Legal Requirements or governmental guidelines or policies.

(b) During all times that Buyer or a Buyer Affiliate or Buyer Subsidiary owns and operates the Hospital Businesses, Buyer will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.20. Capital Commitment.

(a) Within five (5) years of Closing and in consultation with the Local Board, Buyer agrees to (i) spend or commit in a binding contract to spend within a reasonable time period not to exceed six (6) years after the Closing, or (ii) cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend in accordance with the Strategic Business Plan within a reasonable time period not to exceed six (6) years after the Closing, not less than $45,000,000 on capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the Hospital Businesses and within greater Bristol, Connecticut, including, to the extent incorporated in the Strategic Business Plan, the acquisition, development and improvement of hospital, ambulatory or other health care services affiliated with the Hospital.

(b) Notwithstanding the above capital commitment, 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-stock hospitals or other for-profit health care entities, or (ii) causes the Hospital Businesses to suffer a material decline in EBITDA, on a consolidated basis, then, in either event, Buyer shall be required to consult with the Local Board to determine an alternate capital commitment approved by the Local Board and Buyer that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

5.21. Restriction on Sales. As reflected in this Agreement and the Strategic Business Plan prepared in connection herewith, the parties have a shared commitment to ensuring stability and continuity of care, and preserving essential services for the community served by the Hospital and its residents, from and after the Closing Date. In recognition of such objectives, the parties hereby agree as follows:

(a) During the five (5)-year period immediately following the Closing Date ("**Initial Five Year Period**"), without the prior consent of the Local Board (which consent may not be unreasonably withheld, conditioned, delayed, or denied):

(i) Neither VHS CT nor any Affiliate that owns an equity interest in Buyer shall effect or permit any sale or transfer of all or substantially all of the stock or membership interests in Buyer;

(ii) Neither Buyer nor any Affiliate or Subsidiary of Buyer that owns any assets comprising the Hospital Businesses shall effect or permit any sale or transfer of all or substantial assets used in the operation of the Hospital Businesses, including the Investment interests in the Joint Ventures (considered in the aggregate with the other assets of the Hospital Businesses); and

(iii) Neither Buyer nor any Affiliate or Subsidiary of Buyer that owns any assets comprising the Hospital Businesses shall effect or permit any merger, consolidation, spin-off, liquidation or dissolution of any entity or entities that own all or substantial assets constituting the Hospital Businesses.

(b) Upon the expiration of the Initial Five Year Period, for a five (5)-year period thereafter ("**Second Five Year Period**"), neither Buyer nor any Affiliate or Subsidiary of Buyer, as the case may be, shall effect or permit any of the actions listed in Sections 5.21(a)(i)-(iii) prior to consulting in a timely manner with the chief executive officer of the Hospital and the Local Board; *provided* that neither Buyer nor any Affiliate or Subsidiary of Buyer must obtain the consent of the Hospital's chief executive officer or Local Board prior to effecting any of the transactions listed in Sections 5.21(a)(i)-(iii) during the Second Five Year Period.

(c) For purposes of this Section, "substantial assets" means assets of Buyer (as such assets may be upgraded, expanded or changed after Closing) which, in the aggregate, produce at least twenty-five percent (25%) of the total revenue of the Hospital Businesses as calculated at the time of the proposed transaction.

(d) For purposes of this Section, "sale or transfer" shall not include the following: (i) any Subsidiary of Tenet Healthcare that owns an equity interest in an entity owning all or a part of the Hospital Businesses pledging such interest or its accounts receivable pursuant to the Principal Credit Agreement, (ii) the lenders under the Principal Credit Agreement or any other indebtedness of Tenet Healthcare (or their agent acting on their behalf) foreclosing upon such equity interest, or (iii) Buyer or its Affiliates transferring any stock, ownership interests or Assets to one or more of its Affiliates. Furthermore, and notwithstanding anything to the contrary in this Section 5.21, this Section shall not apply to (x) any sale or transfer required by a Governmental Authority, (y) any merger, sale, or other transaction that does not relate solely or principally to the Hospital Businesses, or (z) any corporate-level transactions involving Tenet Healthcare's stock or securities, including macro-level mergers, recapitalizations and reorganizations.

(e) The restrictions contained in this Section 5.21 are subject to exceptions as may be agreed to by the Local Board for exigent regulatory requirements and market demands.

5.22. Right of First Refusal in Favor of Seller.

(a) If, during the ten (10)-year period immediately following Closing, Buyer, VHS CT or any other Affiliate of Buyer that owns an equity interest in Buyer or any assets comprising the Hospital Businesses (an "**Offering Party**") receives an Offer that it desires to accept, such Offering Party shall promptly provide a written notice to Seller that describes the material terms of the Offer. If Seller notifies the Offering Party within sixty (60) days after the date on which notice of the Offer was given to Seller (the "**Election Period**") that Seller irrevocably elects to purchase the equity interests or assets that are the subject of the Offer (the "**Subject Interest**") for the consideration to be paid to the Offering Party pursuant to the Offer (sometimes referred to hereinafter as an "**Affirmative Election**"), then such election shall be binding upon Seller and the Offering Party. If Seller makes an Affirmative Election, the parties shall negotiate in good faith for thirty (30) days after the Election Period the terms and conditions of a definitive agreement to be executed by the Offering Party and Seller containing the principal terms set forth in the Offer, but otherwise containing substantially the same representations and warranties regarding the Hospital Businesses as are set forth in this Agreement, *provided* that any representations and warranties of the Offering Party about the Hospital Businesses shall relate to Buyer's period of ownership only. If the Offer includes any non-cash consideration, Seller shall be entitled to substitute cash in an amount equal to the fair market value of such non-cash consideration. Seller shall acquire the Subject Interest at a closing to be held within five (5) business days following the date upon which the last material regulatory approval required in connection with the sale of the Subject Interest is obtained, subject to reasonable extensions mutually acceptable to the Offering Party and Seller, *provided* that in no event shall the closing be held later than one hundred eighty (180) days after the Offering Party gives Seller written notice of the Offer. Seller shall have the right, upon written notice to the Offering Party, to assign its purchase rights under this Section 5.22 to a designee of Seller; *provided* that such designee does not compete with Buyer or any Affiliate or Subsidiary of Buyer. Such assignment shall not relieve Seller of its obligations under this Agreement.

(b) If (i) Seller fails to make an Affirmative Election within the Election Period, (ii) after making an Affirmative Election and entering into a definitive agreement with the Offering Party, Seller defaults in its obligation under such definitive agreement to timely purchase the Subject Interest, or (iii) the consent of any Governmental Authority or third party required for the consummation of the sale of the Hospital Businesses to Seller cannot be obtained (following Seller's use of commercially reasonable efforts to obtain such consent or consents), then the Offering Party may (but shall not be obligated to) sell the Subject Interest to the offeror on the terms and conditions of the Offer within 180 days after the event described in clause (i), (ii) or (iii) above, *provided* that, if such sale to such offeror does not occur on or before the expiration of such 180-day period, then the provisions of this Section shall apply anew with respect to the sale of the Subject Interest thereafter.

5.23. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller or its Affiliates shall bear and pay all expenses incurred by or on behalf of Seller in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any material monetary payment to a third party or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following Closing costs: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all real estate transfer Taxes and sales and use Taxes, documentary stamps and recording fees arising out of the transfer of the Assets, (iii) the premium for Buyer's title insurance policies described in Section 7.06, and (iv) all similar Closing costs. Seller shall pay the cost of all regulatory filing fees, except as otherwise provided in this Agreement.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

5.24. Medical Staff Matters.

(a) To ensure continuity of care in the community, the Hospital's medical staff members in good standing at Closing will have medical staff privileges at the Hospital immediately after the Closing, subject thereafter to the Hospital's medical staff bylaws then in effect, as amended from time to time. Following the Closing Date, Buyer shall involve physicians of the Hospital's medical staff in the strategic and capital planning processes for the Hospital Businesses, to insure that the critical needs of the medical staff are met and that strategic initiatives and investments in the Hospital

Businesses are prioritized to meet the needs of physicians who practice at the Hospital and their patients.

(b) For a period of five (5) years after Closing, Buyer agrees to consult with the Local Board prior to (i) replacing a hospital-based medical group or physician unless Buyer is doing so in connection with a for-cause termination under such medical group's or physician's then existing contract, or (ii) to the extent permitted by law, placing any Buyer or Buyer Affiliate or Subsidiary employed physician at any location within the Hospital's service area. For purposes of this Section, the Hospital's "service area" includes the towns of Bristol, Plainville, Wolcott, Southington, and Terryville. For purposes of this Section, "Buyer or Buyer Affiliate or Subsidiary-employed physician" shall not include any physician employed by BHMSG or serving on the medical staff of the Hospital immediately prior to Closing, or employed by BHMSG's successor entity, or serving on the medical staff of the Hospital after Closing.

(c) Buyer shall work together with the physicians on the medical staff of the Hospital to develop the medical staff bylaws, rules and regulations, medical staff committee structure, credentialing plan, and fair hearing plan of the Hospital following the Closing.

(d) Buyer will encourage and support participation by both independent and employed physicians who are members of the Hospital's medical staff in Buyer's or Buyer Affiliate's or Subsidiary's Physician Leadership Council. The initial physicians to serve on the Physician Leadership Council are set forth on Schedule 5.24(d).

5.25. Communications. Buyer and its agents, consultants and employees shall not until Closing, without prior notice to the Seller and without the presence of the Seller or its consent, which shall not be unreasonably withheld, conditioned or delayed, have any communications with the employees, unions, contractors, service providers, suppliers, tenants or prospective tenants, with respect to the Hospital Businesses and Properties.

5.26. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so.

5.27. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

5.28. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.29. Tail Insurance. On or before the Closing Date, Seller will purchase and obtain an unlimited extended claims reporting provision for all primary and excess insurance policies in force as of the date of this Agreement that cover Seller or the Hospital Businesses and each physician employee of Seller (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement related to all periods prior to the Closing. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder as their interests may appear.

5.30. Strategic Business Plan. Within the 120 day period immediately following the Closing, the parties shall collaboratively develop the Strategic Business Plan, which shall include (i) opportunities to expand the Hospital Businesses' service lines within the community, (ii) supporting recruitment and retention of primary care and specialty care physicians in the community, and employing or contracting with such physicians by an entity aligned or affiliated with the Hospital, (iii) developing a tertiary affiliation and becoming part of a network or system of health care providers that spans the care continuum, and includes preventive care, ambulatory care, urgent care, acute care, chronic care, post-acute care, behavioral health care, rehabilitation, and home care services accessible to the community, and (iv) developing or obtaining the information technology, medical home and medical management infrastructure to provide patient-centric, population health management and assume financial risk for managing the quality and cost of health care services provided to defined populations in the community. After the Strategic Business Plan is developed, Buyer will use commercially reasonable efforts to execute and implement the Strategic Business Plan in accordance with its terms, as the Strategic Business Plan may be modified by Buyer from time to time; *provided* that any material modification to the Strategic Business Plan shall be subject to the prior approval of the Local Board.

5.31. Parent and Child Program. Seller shall have caused a non-profit corporation to be formed in the State of Connecticut for purposes of operating the Parent and Child Program on a tax-exempt basis from and after the Closing. Prior to the Closing, (i) Seller shall transfer and assign to such entity all Excluded Assets described on Schedule 2.02(q) used by Seller in its operation of the Parent and Child Program as currently conducted and caused such entity to assume all Excluded Liabilities described on Schedule 2.03(m) relating to the Parent and Child Program as currently conducted, and (ii) such newly-formed corporation shall offer to employ all Seller employees whose current position primarily relates to the Parent and Child Program.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Buyer was true and correct in all

material respects on and as of the date of this Agreement, each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened in writing to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Attorney General, required for Seller to consummate the transactions contemplated by this Agreement.

6.04. Redemption of the Bonds/Satisfaction of the Indenture. All actions required to be taken and all conditions required to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, including the CHEFA Bonds, and the satisfaction, discharge, release, and termination of all trust indentures and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have been, or at Closing will be, taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from Foley & Lardner LLP or from a nationally recognized bond counsel with respect to the defeasance of the CHEFA Bonds and the Trust Indenture dated as of January 1, 2002 between CHEFA and the Trustee identified therein to the effect that Seller may transfer and convey the Assets to Buyer free and clear of the Indenture and all Encumbrances created by or in connection therewith.

6.05. Strategic Business Plan. The parties shall have agreed upon the Strategic Business Plan, in a form reasonably satisfactory to Seller.

6.06. Extraordinary Events. Neither Buyer nor Tenet Healthcare nor any Subsidiary of Tenet Healthcare that directly or indirectly holds any equity interest in Buyer (a) is in receivership or dissolution, (b) has made any assignment for the benefit of creditors, (c) has admitted in writing its inability to pay its debts as they mature, (d) has been adjudicated a bankrupt, (e) has 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 or statute of the United States or any state (and no such petition has been filed against Buyer or Tenet Healthcare or any Subsidiary of Tenet Healthcare that directly or indirectly holds any equity interest in Buyer), or (f) has entered into any Contract to do any of the foregoing on or after the Closing Date.

6.07. Physician Alignment. Tenet Healthcare shall have caused a medical foundation (the "Foundation") to be formed in the State of Connecticut. Tenet Healthcare or an Affiliate thereof will be the sole member of the Foundation, which will employ licensed physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, including those licensed physicians and other licensed Providers employed by BHMSG immediately prior to the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Seller in this Agreement is true and correct in all material respects on and as of the Closing Date (other than the representations in Section 3.08(l) which shall be correct in all respects).

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of Seller's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by Seller, and approved by Buyer, all in accordance with Section 10.01.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

7.03. Material Adverse Change. Since the date hereof, no Material Adverse Change has occurred and no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Change.

7.04. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) Buyer has received confirmation from all applicable Governmental Authorities that all Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any condition that is materially more burdensome to the operation of the Hospital Businesses after Closing as compared to pre-Closing;

(b) Buyer has received reasonable assurances that the applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospital, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) Buyer has received (i) all other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Attorney General, required for Buyer to consummate the transactions contemplated by this Agreement, and such consents, approvals, licenses and other authorizations (including any conditions imposed on the transactions by any Governmental Authority) are in standard form and do not impose any conditions that Buyer, in its reasonable discretion, determines to be materially burdensome, and (ii) all other material consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to operate the Hospital Businesses after Closing; and

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts that are listed on Schedule 7.04(d) and all other consents, waivers, and estoppels of third parties that are reasonably necessary, in the reasonable opinion of Buyer, to effectively complete the transactions contemplated herein have been obtained and are in a form and substance reasonable satisfactory to Buyer; *provided*, that, to the extent any such consent(s) and/or assignment(s) cannot be obtained after good faith efforts, the parties shall use good faith efforts to place Buyer in the same position as if such consent(s) and/or assignment(s) had been obtained; *provided, further* that in no event shall Seller or any Seller Affiliate or Subsidiary be obligated to violate or breach any lease or other agreement in making alternative arrangements or in holding any such Assumed Contract in trust for the use and benefit of Buyer hereunder.

7.05. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state (and no such petition has been filed against any it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.06. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a recognized national title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably acceptable to Buyer and with such endorsements as Buyer may reasonably require, at Buyer's sole cost and expense; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company, at Buyer's sole cost and expense.

7.07. Opinion of Seller's Counsel. Buyer has received an opinion from counsel to Seller, dated as of the Closing Date and addressed to Buyer, in a form reasonably satisfactory to Buyer.

7.08. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture, specifically the CHEFA Bonds, shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in Section 6.04.

7.09. Environmental Assessments. Buyer shall have received a Phase I environmental report, in a form reasonably satisfactory to Buyer and at Buyer's sole cost and expense, on each parcel of Owned Real Property and, at Buyer's option, any portion of the premises forming a part of the Leased Real Property. The parties shall have entered into an Access Indemnity Agreement in connection with such Phase I environmental report, in substantially the form of Exhibit D hereto.

7.10. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.11. Strategic Business Plan. The parties shall have agreed upon the Strategic Business Plan, in a form reasonably satisfactory to Seller.

7.12. Physician Alignment. Tenet Healthcare shall have caused the Foundation to be formed in the State of Connecticut. Tenet Healthcare or an Affiliate thereof will be the sole member of the Foundation, which will employ licensed physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, including those licensed physicians and other licensed Providers employed by BHMSG immediately prior to the Closing Date.

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Hospital Businesses and the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at the office of Foley & Lardner LLP, 111 Huntington Avenue, Boston, Massachusetts at 10:00 a.m., or at such other place and time as the parties may mutually agree, on _____, 2014, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, Tenet Healthcare.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Hospital Businesses and the Assets.

8.02. Action of Seller at Closing.

At the Closing, Seller shall deliver to Buyer:

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

(e) limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit C attached hereto, fully executed by Seller;

(f) an original or certified copy of the tail insurance policies required by Section 5.29 and receipts evidencing payment of the premiums therefor;

(g) a copy of resolutions duly adopted by the board of directors, trustees or shareholders of Seller, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated therein, certified as in full force and effect as of the Closing Date by the appropriate officers of such Seller;

(h) a certificate of a duly authorized officer of Seller certifying that (i) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(i) a certificate of incumbency for the officers of Seller executing this Agreement and the Closing Documents;

(j) a certificate of existence and good standing for Seller and each of its Subsidiaries from the State of Connecticut, dated the most recent practicable date prior to the Closing Date;

(k) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Joint Ventures, duly endorsed for transfer to Buyer, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer

(l) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of Seller or any Affiliate conveying an interest in Owned Real Property to Buyer or its Affiliates, certifying that such entity is not a foreign corporation and is not otherwise a foreign Person;

(m) 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 Assets;

(n) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets, including for all motor vehicles;

(o) all necessary state and local real estate conveyance tax forms duly executed by Seller;

(p) final execution copy of the Transfer Act Form III and ECAF, as more fully described in Section 5.09;

(q) commitments to deliver after Closing in ordinary course UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing;

(r) the opinion of counsel to Seller as provided in Section 7.07;

(s) owner's affidavits, certificates, rent rolls and other documentation that may be reasonably necessary to consummate the transactions contemplated by this Agreement and obtain the title policies required to be issued hereunder; and

(t) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) the portion of the Purchase Price due to Seller, in accordance with Section 2.05(b)(i);

(b) the portion of the Purchase Price due to the Community Foundation, in accordance with Section 2.05(b)(ii);

(c) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities;

(d) the Local Board Bylaws in substantially the form of Exhibit A attached hereto;

(e) the Operating Agreement, in substantially the form of Exhibit B attached hereto, as in effect as of the Closing Date;

(f) a copy of resolutions duly adopted by the boards of directors, members or managers of Tenet Healthcare and Buyer, as appropriate, authorizing and approving the execution and delivery of this Agreement, the Local Board Bylaws, the Operating Agreement, and the other Closing Documents and the consummation of the transactions

contemplated therein, certified as in full force and effect as of the Closing Date by the appropriate officers of Tenet Healthcare and Buyer;

(g) a certificate of a duly authorized officer of Buyer certifying that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of Buyer in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(h) a certificate of incumbency for the officers of Tenet Healthcare and Buyer executing this Agreement and the Closing Documents;

(i) a certificate of existence and good standing of Buyer from the State of Delaware, dated as of the most recent practicable date prior to the Closing Date; and

(j) such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Article 7, following prior written notice to Seller and sixty (60) days' opportunity to cure; (iii) by Seller, by written notice to Buyer if any event occurs or condition exists which causes Buyer to be unable to satisfy one or more conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Article 6, following prior written notice to Buyer and sixty (60) days' opportunity to cure; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before _____, 2015 (as such date may be extended by mutual agreement of Seller and Buyer); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; (v) by Buyer, pursuant to Section 5.15 hereof; or (vi) by either Buyer or Seller pursuant to Section 10.01 hereof.

(b) In the event that this Agreement is terminated by Buyer or Seller (the "**Terminating Party**") because the other party (the "**Breaching Party**") refuses to close the transactions contemplated by this Agreement in violation of Section 5.27 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, pay to the Terminating Party by wire transfer of immediately available funds to an account designated by the Terminating Party a fee equal to $2,500,000 (the "**Termination Fee**"). The parties acknowledge and agree that the agreements contained in this Section are an integral part of the transaction contemplated by this Agreement and constitute liquidated damages and not a penalty. If the Breaching Party fails to pay the Termination Fee in accordance with the terms of this Section 8.04(b), then the Breaching Party shall pay the costs and expenses (including legal fees and expenses) of the Terminating Party in connection with any action, including the filing of any lawsuit or other legal action, taken to collect payment, together with interest as provided in Section 10.20 from the date such Termination Fee was required to be paid. Notwithstanding anything to the contrary in this Agreement, the Terminating Party's right to receive payment of the Termination Fee pursuant to this Section 8.04(b), and the right to receive the payment of its costs and expenses as provided in this Section 8.04(b), shall be the sole and exclusive remedy of the Terminating Party against the Breaching Party and its Affiliates for any and all Losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with this Section 8.04(b), neither the Breaching Party nor any of its Subsidiaries or Affiliates or their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(c) If this Agreement is validly terminated pursuant to this Section 8.04, this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of Section 5.23 and the confidentiality provisions of Section 10.22 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Subsidiary or Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent, provided in this Article 9, from and after the Closing, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof;

(b) any breach or nonfulfillment of any covenant or agreement of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(c) the Excluded Liabilities; and

(d) any actual damages (including attorneys' fees) resulting from claims by any creditor of Seller relating to a claim in existence as of the Closing Date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable state or federal insolvency, bankruptcy, bulk sales, fraudulent conveyance or creditors' rights Legal Requirements.

9.02. Seller's Limitations.

(a) Seller will have no liability under Section 9.01(a) and no claim will accrue against Seller under Section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 9.01(a) exceeds $500,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.01(a) in excess of the Seller Deductible, *provided* that liability of Seller shall arise for all Losses resulting from Seller's intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

(b) The aggregate liability of Seller to Buyer's Indemnified Persons for indemnification under Section 9.01(a) shall not exceed $10,000,000 except that there shall be no limitation of Seller's liability for indemnification under Section 9.01(a) in respect of Losses resulting from Seller's intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

(c) In no event shall the Community Foundation be deemed an indemnitor hereunder.

9.03. Indemnification by Buyer. Subject to and to the extent provided in this Article 9, from and after the Closing Date, Buyer shall indemnify, defend and hold harmless Seller's

Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof;

(b) any breach or nonfulfillment of any covenant or agreement of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities;

(d) Buyer's use of Seller's licenses and registrations relating to controlled substances and the operation of pharmacies and laboratories under Section 5.08 hereof, as provided in the limited powers of attorney executed by the parties; and

(e) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

9.04. Buyer's Limitations.

(a) Buyer will have no liability under Section 9.03(a) and no claim will accrue against Buyer under Section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 9.03(a) exceeds $500,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

(b) The aggregate liability of Buyer to Seller's Indemnified Persons for indemnification under Section 9.03(a) shall not exceed $10,000,000, except that there shall be no limitation of Buyer's liability for indemnification under Section 9.03(a) in respect of Losses resulting from Buyer's intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

9.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 9 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies

of all relevant written documentation, including papers served, if any, and a reasonably accurate summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within fifteen (15) days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within fifteen (15) days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee if such settlement includes any non-monetary relief or does not include a full release of the Indemnitee). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, with prior written notice to the Indemnifying Party and at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not reasonably likely to be prejudicial to the Indemnifying Party (it being understood that, except as provided in Section 9.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. If (1) the Persons against whom the Third Party Claim is made, or

any impleaded Persons, include both one or more Buyer's Indemnified Persons and one or more Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, then either (a) the Indemnifying Party shall retain separate counsel with respect to each such party, or, if Indemnifying Party fails to retain such separate counsel in a timely manner, Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the reasonable expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim (following written notice from the Indemnitee and a reasonable opportunity to cure), or if the Indemnifying Party is precluded by the last sentence of Section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided*, however, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld) and (B) the reasonable out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates), and *provided*, *further* that the Indemnifying Party shall be entitled to may participate in, but not control, any defense or settlement of any Third Party Claim contested by the Indemnitee hereunder.

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within thirty (30) days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee

hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the thirty (30)-day period in which to respond pursuant to Section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within sixty (60) days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such sixty (60)-day period, it shall be resolved pursuant to Section 10.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within ten (10) days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 10.20.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 9.05(a)(i) and Section 9.05(b)(i), as applicable.

9.06. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of Buyer to investigate the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations, warranties and covenants of the other in this Agreement. The representations, warranties and covenants of Seller and Buyer in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 2.04, 3.01, 3.02, 3.03, 4.01, 4.02, 4.04, 8.04(b), 8.04(c), 8.04(d), 9.01(c)-(d),

9.03(c)-(e), 10.15, 10.22 and 10.23; (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.11, 3.12(a) and 3.13; and (c) until the second anniversary of the Closing Date in the case of all other representations, warranties and covenants, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before the expiration of such representation or covenant until the claim for indemnification has been satisfied or otherwise resolved as provided in this Article;

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, or intentional nonfulfillment or breach of any covenant in this Agreement or any Closing Document, all representations, warranties and covenants that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until sixty (60) days after the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach; and

(iii) covenants to be performed or complied with after the Closing Date will survive the Closing until sixty (60) days after the end of the term specified therein, or, if no term is specified, indefinitely.

9.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any third party claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

9.08. Disclaimer of Special Damages. Notwithstanding anything to the contrary set forth in this Agreement, no Indemnifying Party or other party to this Agreement shall be liable to

or otherwise responsible to any Indemnitee for exemplary, punitive, consequential, indirect, incidental or other special damages (including loss of revenue, income or profits) for any matter indemnifiable hereunder or otherwise arising out of or relating to this Agreement or the transactions contemplated hereby, unless such damages are incurred in connection with a Third Party Claim.

9.09. Indemnity Reserve. Seller agrees to maintain an indemnity reserve in the amount of $2,500,000 for a period of three (3) years after the Closing so that Buyer will have meaningful financial recourse against Seller for indemnification claims. Notwithstanding the foregoing, however, if one or more indemnification claims is initiated by Buyer within the three-year indemnification reserve period, then the indemnification reserve shall be extended for an additional period beginning on the date the last claim was initiated during such three (3)-year reserve period and ending upon the later of (i) the final resolution of all claims initiated by Buyer and (ii) the first anniversary of such last claim made during the three-year reserve period.

9.10. Exclusive Remedy. From and after the Closing, except in cases of fraud or intentional misrepresentation or equitable relief sought pursuant to Section 10.02, the rights to indemnification pursuant to this Article 9 will be the sole and exclusive remedy of the parties to this Agreement with respect to any and all matters arising out of or relating to this Agreement or the transactions contemplated hereby. This Section does not preclude or limit the operation of Section 10.04 with respect to any dispute covered thereby nor does this Section preclude or limit any party from initiating or otherwise participating in any Proceeding otherwise permitted by this Agreement to interpret or enforce the parties' respective rights, remedies and obligations pursuant to this Article 9.

10. GENERAL

10.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, Seller and Buyer shall update its Schedules as reasonably necessary, such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner. If Buyer, in its reasonable discretion, determines that it should not consummate the transactions contemplated by this Agreement because of any information contained in a Schedule, Exhibit, or other instrument that is delivered to Buyer after the execution of this Agreement, then Buyer may terminate this Agreement on or before the Closing by giving written notice thereof to Seller.

(b) Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and

warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself). Disclosure of an exception under one schedule is sufficient for full disclosure by the Seller. It shall not be necessary to make the same disclosure under multiple schedules so long as the intent for information disclosed under one schedule to apply to multiple schedules is readily apparent.

10.02. Equitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 9).

10.03. Other Owners of Assets. Buyer, Seller and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to, such Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement. The provisions of this Section 10.03 shall not apply to BHDF.

10.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 10.14 hereof, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 10.04(a) within thirty (30) days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within fifteen (15) days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Any mediation conducted hereunder shall be held in Bristol, Connecticut. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of sixty (60) days, unless a longer period is otherwise agreed.

10.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

10.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may, subject to Section 10.22 hereof, be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

10.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller and Buyer shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Contract, claim or right. In no event shall Seller be required to incur material costs, initiate litigation or accept a concession in order to obtain any consent.

10.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Bristol, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Bristol, Connecticut are permitted or required to be closed.

10.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

10.10. Choice of Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any 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.

10.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate an Affiliate to purchase any or all of the Assets, including the Hospital Businesses, *provided* that Tenet Healthcare shall unconditionally guarantee any and all obligations of such Affiliate pursuant to Section 10.23, and (ii) Buyer and Tenet Healthcare shall be permitted to grant a security interest in and collaterally assign and transfer all of their rights, interests and benefits, but not their obligations, under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of the Seller. Buyer shall cause any Person that acquires, directly or indirectly, a controlling interest in Buyer, whether through the purchase of all or substantially all of the assets of the Hospital Businesses, a purchase of equity or a merger or consolidation, to assume, honor and perform Buyer's obligations hereunder, in accordance with the terms of this Agreement; provided, that if the acquisition of the controlling interest in Buyer is through an equity purchase, then Buyer agrees that its obligations under this Agreement and the Ancillary Agreements will not be excluded from such transaction.

10.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not

be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms.

10.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

10.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: **[VHS Bristol Health System]**, LLC
c/o Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
Attn: Trip H. Pilgrim
Fax:_____
Email: trip.pilgrim@tenethealth.com

with a copy to (which shall not constitute notice):

Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
Attn: Senior Counsel
Fax: 469.893.7147
Email: jeff.peterson@tenethealth.com

If to Seller: Bristol Hospital and Health Care Group, Inc.
41 Brewster Road
Bristol, CT 06010
Attn: Kurt A. Barwis, FACHE,
President and Chief Executive Officer
Fax:_____
Email: kbarwis@bristolhospital.org

with a copy to (which shall not constitute notice):

Foley & Lardner LLP
111 Huntington Avenue
Suite 2600
Boston, MA 02199-7610
Attn: Michael L. Blau, Esq.
Fax: 617.342.4001
Email: mblau@foley.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

10.15. Misdirected Payments; Physician Loans. After Closing, (a) Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates) constituting or in respect of the Assets and Assumed Liabilities, and (b) Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. If Buyer suffers any deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence), Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. Any amounts payable pursuant to this Agreement that are due Buyer by Seller or one of its Affiliates, or due Seller by Buyer or one of its Affiliates, may be offset against monies or other funds owed by the party entitled to receive payment to the party required to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause its Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

10.16. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

10.17. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate governmental agencies shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

10.18. Entire Agreement; Amendment. Except as set forth in Section 10.22(a), this Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 9.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

10.19. Counterparts; Transmission by Electronic Means. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

10.20. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A., during such period plus three percent *per annum*.

10.21. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

10.22. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements, Seller and Buyer (and their respective Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party. With respect to information provided by a party to the other party in connection with and relative to this proposed transaction, the Confidentiality Agreement, dated January 9, 2012, between Vanguard Health Systems, Inc. and Seller shall remain in full force and effect during the term hereof, shall survive termination of this Agreement, and shall be binding upon Buyer for purposes of confidentiality. It is understood by the parties hereto that the information, documents, and instruments delivered by a party to the other party hereto are of a confidential and proprietary nature. Buyer and Seller shall comply with and recognize all confidentiality and non-disclosure requirements that apply to Seller 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 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. Each of the parties hereto recognizes that any breach of this Section 10.22 would result in irreparable harm to the other party to this Agreement and its 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.

(b) At all times before and after the Closing, Seller, on the one hand, and Tenet Healthcare and Buyer, on the other hand, will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release with respect to this Agreement or the transactions contemplated by this Agreement to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

10.23 Guarantee of Buyer's Obligations. Tenet Healthcare, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, Tenet Healthcare will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will

remain in full force and effect indefinitely (in light of the fact that, as provided in Section 9.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. Tenet Healthcare's obligations under this Section 10.23 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

[*Signature Page Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.

By: _____

Title: _____

[VHS BRISTOL HEALTH SYSTEM], LLC

By: _____

Title: _____

TENET HEALTHCARE CORPORATION

By: _____

Title: _____

VHS OF CONNECTICUT, LLC

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 10.03.

ACKNOWLEDGED BY:

BRISTOL HOSPITAL, INC.

By: _____

Title: _____

BRISTOL HOSPITAL MULTISPECIALTY GROUP, INC.

By: _____

Title: _____

BRISTOL HOSPITAL EMS, LLC

By: _____

Title: _____

BRISTOL HEALTH CARE, INC.

By: _____

Title: _____

Exhibits to be attached:

Exhibit A	Local Board Bylaws
Exhibit B	Operating Agreement
Exhibit C	Form of Limited Power of Attorney
Exhibit D	Access Indemnity Agreement

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 2: CONFIDENTIAL INFORMATION SUMMARY

Confidential Information Summary

January 2012

Summary: 20120123_HHC07

CAIN BROTHERS

This Confidential Information Summary ("CIS") has been prepared on behalf of Bristol Hospital and Health Care Group, Inc. and its wholly owned subsidiaries and affiliated entities (collectively, the "Company") based on information from the Company and published sources, and is being furnished through Cain Brothers, as the Company's exclusive authorized representative, for informational purposes solely for use by qualified prospects in considering their interest in entering into a partnership, purchase, merger or other form of business combination with the Company (a "Transaction"). The information contained herein is subject to change without notice. Neither the Company nor Cain Brothers assumes any responsibility to update any information contained in this CIS or to inform the recipient of information which may affect this CIS. This CIS has been prepared to assist interested parties in making their own evaluation of the Company and does not purport to be all-inclusive or to contain all information that a prospective party to a Transaction may desire or that may be required in order to properly evaluate the business, prospects or value of the Company. In all cases, interested parties should conduct their own investigation and analysis of the Company and the data set forth in this CIS. Industry data and statistics have been obtained or derived from the Company and published industry sources.

By accepting this CIS, the recipient acknowledges and agrees that all of the information contained herein is highly confidential and subject to the Non-Disclosure Agreement ("NDA") executed by the recipient. Without limiting the generality of the foregoing: (1) the recipient will not reproduce this CIS in whole or in part; (2) if the recipient does not wish to pursue a Transaction relating to the Company, it will (i) promptly return to Cain Brothers hard copies or delete electronic copies of this CIS, together with any other materials relating to the Company which the recipient may have received in written or electronic form from the Company, Cain Brothers or any of their respective subsidiaries or affiliates and (ii) take such other actions, if any, required by the NDA; (3) the recipient will hold all information and the fact that it is involved in any process relating to the Company and the status thereof as confidential and will not disclose any of the information; and (4) any proposed actions by the recipient which are inconsistent in any manner with the NDA will require the prior written consent of the Company.

Cain Brothers has not independently verified any of the information contained herein, and neither the Company, Cain Brothers nor any of their respective affiliates makes any representation or warranty (expressed or implied) as to the accuracy or completeness of this CIS or any statements, estimates or projections contained herein. Such statements, estimates and projections reflect various assumptions made by the Company concerning anticipated results, which are subject to business, economic and competitive uncertainties and contingencies, many of which are beyond the control of the Company and which may or may not prove to be correct. As a result, no representation or warranty is made as to the feasibility or attainability of the projected financial information or the accuracy or completeness of the assumptions from which the projected financial information is derived. There can be no assurance that the projections will be realized. This CIS speaks only as of the date hereof or as of the date indicated. This CIS does not constitute an offer or invitation for the sale or purchase of the securities, assets or business described herein. The only information that will have any legal effect will be that specifically represented, warranted and contained in a definitive agreement relating to a Transaction and executed by the Company and a prospective Transaction party. The Company and Cain Brothers disclaim liability for any loss or damage incurred as a result of any information contained in or omitted from this CIS.

The Company reserves the right to negotiate with one or more qualified prospects at any time and to enter into a definitive agreement relating to a Transaction without prior notice to the recipient or other prospective Transaction parties. Further, the Company reserves the right, at any time, to terminate the process and / or to modify any procedures without giving advance notice or providing any reason therefore. The Company also reserves the right during the evaluation period to take any action, whether within or outside the ordinary course of business.

INFORMATION REQUESTS

Cain Brothers is the Company's exclusive financial advisor. Under no circumstances should any interested party directly contact the Company, any of its directors, employees, medical staff, patients or suppliers, for any reason in connection with their evaluation of the Company. All inquiries regarding this Confidential Information Summary or the Company should be directed to the following persons:

Jim Cain Managing Director (212) 981-6955 jcain@cainbrothers.com	**Jason D. Horowitz** Senior Vice President (212) 981-6951 jhorowitz@cainbrothers.com
Nichole Kim Analyst (212) 981-6919 nkim@cainbrothers.com	**Doug Fullerton** Analyst (212) 981-6890 dfullerton@cainbrothers.com

Cain Brothers & Company, LLC
360 Madison Avenue, 5th Floor
New York, New York 10017
Telephone: (212) 869-5600

Table of Contents

I. Process Overview 5
A. Organization 5
B. Objectives 5
C. Phase I – Preliminary Interest Response 6
D. Phase II – Additional Due Diligence 7
E. Phase III – Binding Proposals 7
F. Changes to the Selection Process 7
G. Costs and Expenses 7
II. Executive Summary 9
A. Background 9
B. Overview 9
C. Summary Financial and Operating Statistics 10
III. Service Area Profile 15
A. Demographics 16
B. Competition 17
IV. Appendices 20
Appendix A – 2011 BHHCG Audited Financials 21
Appendix B – 2011 Hospital Audited Financials 22

I. Process Overview

A. Organization

Bristol Hospital and Health Care Group, Inc. (together with its affiliates, "BHHCG" or the "Company") (http://www.bristolhospital.org) is a Connecticut non-stock, 501(c)(3) corporation. BHHCG consists of numerous legal entities, joint ventures ("JVs") and affiliations, including the flagship asset, The Bristol Hospital (the "Hospital" or "Bristol Hospital"). Bristol Hospital is a full-service healthcare institution providing a comprehensive range of inpatient, outpatient and ancillary services for residents of Bristol and the surrounding community. The Hospital is a 154-bed facility located at Brewster Road in Bristol, Connecticut. As of September 30, 2011, the Hospital has a staff of 843 full-time equivalents. There are 296 medical staff members.

B. Objectives

BHHCG's Board of Directors (the "Board"), through an authorized sub-committee (the "Partnership Committee"), has engaged Cain Brothers to explore potential strategic partnership opportunities with a limited number of health care service providers currently operating in or interested in entering the central Connecticut market. At the Partnership Committee's direction, Cain Brothers is requesting proposals from these pre-selected participants interested in a long-term strategic relationship with BHHCG. The core objective is to ensure BHHCG's continued acute care facility presence and long-term vigor as a provider of leading health care services to the residents of the Company's service areas. Based on this overarching goal, BHHCG intends to evaluate potential partners who can demonstrably help in the achievement of the following objectives (the "Objectives"):

1. Ensure Bristol Hospital remains a viable, acute care hospital, providing the highest safety and quality health care services to the Greater Bristol community for the long-term;
2. Provide access to sufficient capital to enhance and expand existing service lines in order to increase the volume of existing core services provided by the Hospital and minimize the outmigration of patients to other facilities;
3. Develop an expanded line of core health care services for the Hospital including orthopedics, vascular and thoracic surgery;
4. Develop or enhance BHHCG's existing comprehensive physician recruitment and retention strategy
5. Provide access to capital to meet BHHCG's current and future capital needs while strengthening the balance sheet;
6. Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
7. Continue charitable care delivery and funding.

The Partnership Committee is requesting proposals from organizations, which can therefore demonstrate:

- An alignment in mission, culture and ability that supports BHHCG;
- A commitment to making substantial future capital investments in BHHCG in order to ensure that BHHCG continues to provide the Greater Bristol community access and choice to exceptional high quality, cost effective health care;

- A commitment to ensure a culture of high quality care throughout the system as a distinguishing feature, through quality clinical care programs and the encouragement of healthy life styles and prevention programs;
- A history of commitment to providing appropriate charitable care to the communities it serves; and
- The intent and ability to complete a transaction within a reasonable time frame.

C. Phase I – Preliminary Interest Response

BHHCG, through Cain Brothers, is inviting selected interested organizations to ***submit a written, preliminary, non-binding indication of interest ("Preliminary Proposals")***, based on the information provided herein and/or related information provided by BHHCG.

Your proposal should be submitted electronically no later than ***5:00 pm Eastern Standard Time on January 27, 2012~~January 20, 2012~~*** in Microsoft Word® format to Jason D. Horowitz (jhorowitz@cainbrothers.com). Any additional materials supplementing your proposal may be submitted in Adobe PDF® or other electronic format.

After receipt of Preliminary Proposals, BHHCG plans to select a limited number of participants to continue to Phase II.

BHHCG requests that the proposal be as specific and detailed as possible. In order to be considered responsive and to allow for appropriate analysis, proposals should address the elements outlined below:

1. Please provide an introduction to your organization including but not limited to the organization's tax status, senior management team, capital structure and strategies for affiliating and partnering with community hospitals. Also, please provide an overview of your organization's sources and access to capital and how the allocation of capital resources to affiliated organizations is determined. Describe any existing affiliations with other health care entities.
2. Please provide an overview of your organization's activities in Connecticut and specifically in markets in and around Hartford. If your organization does not currently operate in Connecticut, please provide an overview of your organization's strategic plans related to entering this market.
3. What, if any, potential conflicts do you envision having with BHHCG's primary objectives (maintaining acute care services in the greater Bristol area, enhancing and expanding existing service lines and providing access to sufficient amounts of capital in order to meet BHHCG's strategic goals), its facilities and services. Do any of your existing operations currently comprise Bristol's primary and secondary service areas? Do any of your existing operations in these markets present opportunities for BHHCG to expand and / or enhance its delivery to its primary and secondary service areas?
4. Based on the information you have been provided or any other information currently in your possession, please describe the governance and organizational structure(s) you would envision in developing a formal relationship with BHHCG. Since the Company's Directors and management are aware of many partnering and affiliation structures being implemented in today's market, the Company will consider structures that will help it facilitate its primary objectives goals. Please identify any governance rights and responsibilities of the existing BHHCG Board of Directors which you would propose to modify.

5. Please add any other thoughts you may have that will help Bristol evaluate the potential advantages of an affiliation or partnership with your organization.

Site visits and management discussions will not be conducted prior to the first proposal submission deadline.

Furthermore, please do not contact any of the employees, members of the BHHCG, including but not limited to the Board of Directors, management, or medical or line staff without the prior, written consent of Cain Brothers.

Once received, Cain Brothers will review your proposal and follow-up with any aspects of your proposal that may need elaboration or clarification.

D. Phase II – Additional Due Diligence

Phase II is intended to provide the information that a qualified respondent will need in order to submit a more substantive, non-binding proposal, primarily through access to a BHHCG virtual data room, site visit and management discussions. We anticipate Phase II to begin the Week of January 30 and last three weeks. The culmination of Phase II will result in a written, non-binding, letter of intent, with specific, detailed questions to be distributed by Cain Brothers no later than February 17, 2012.

In order to maintain an orderly and consistent flow of information to Phase II participants, any requests for additional due diligence information should be submitted to Cain Brothers in writing. Cain Brothers will distribute responses to information requests to all Phase II participants.

E. Phase III – Binding Proposals

A binding, definitive proposal will be due following the completion of the Phase II. These final proposals will include a Definitive Agreement to be provided by BHHCG prior to submission of the binding proposal. As soon as feasible, following the submission of a binding proposal, BHHCG, with the advice of Cain Brothers and BHHCG's legal counsel, will evaluate the proposal to determine if it will be recommended for acceptance.

BHHCG shall have no obligation to accept any proposal, whether or not such proposal represents the best offer for BHHCG. An offer will be accepted only upon the execution and delivery of a Definitive Agreement. Until such time that a Definitive Agreement has been executed, BHHCG will not have any obligation to any potential partner with respect to any transaction involving BHHCG. Following such time, BHHCG's only obligation will be as set forth in a Definitive Agreement.

F. Changes to the Selection Process

BHHCG's intent is to identify partnering alternatives and potentially a candidate with whom to complete a transaction meeting the Objectives as quickly as feasible. Therefore, BHHCG expressly reserves the right to consider any and all factors in the selection of a proposal and to deal with any party individually or simultaneously with other prospective partners. BHHCG may alter these and any other procedures, as it deems necessary and appropriate. BHHCG also reserves the right, at its sole discretion, to reject any and all expressions of interest or proposals and to terminate the process in its entirety, or with respect to any prospective partner, at any time.

G. Costs and Expenses

Each participant agrees to bear all costs of its own investigation and evaluation of the operations of BHHCG, including the fees and disbursements to its own counsel and advisors. No finders' fees, brokers' fees, or commissions will be paid by BHHCG, except to its own advisors, in connection with any transaction which may result.

II. Executive Summary

A. Background

BHHCG is a Connecticut non-stock, 501(c)(3) corporation consisting of Bristol Hospital, Incorporated, Bristol Hospital Development Foundation, Inc., Bristol Health Care, Inc., Bristol Hospital EMS, LLC and Bristol Hospital Multispecialty Group, Inc., the largest of which is Bristol Hospital. Bristol Hospital was founded in 1919.

The Company, through its Partnership Committee, has engaged Cain Brothers to explore potential strategic partnership opportunities as described previously. These opportunities are intended to meet BHHCG's core objectives:

- Ensure Bristol Hospital remains a viable, acute care hospital, providing the highest safety and quality health care services to the Greater Bristol community for the long-term;
- Provide access to sufficient capital to enhance and expand existing service lines in order to increase the volume of existing core services provided by the Hospital and minimize the outmigration of patients to other facilities;
- Develop an expanded line of core health care services for the Hospital, including orthopedics, vascular and thoracic surgery;
- Develop or enhance BHHCG's existing comprehensive physician recruitment and retention strategy
- Provide access to capital to meet BHHCG's current and future capital needs while strengthening the balance sheet;
- Maintain high satisfaction scores by patients, physicians, employees and volunteers; and
- Continue charitable care delivery and funding.

B. Overview

Bristol Hospital, the flag-ship asset in BHHCG, is a full-service healthcare institution located at Brewster Road in Bristol, Connecticut, located approximately 20 miles southwest of Hartford. The 154-licensed bed hospital has a long history of service excellence and has earned national recognition for its commitment to providing outstanding patient care. Bristol Hospital provides a comprehensive range of inpatient, outpatient and ancillary services for residents of Bristol and the surrounding community.

The Hospital offers a complete range of patient services including:

- First-rate emergency care center that cares for over 40,000 patients each year;
- New 50,000 square-foot state-of-the-art surgical center;
- Family-centered, single-room maternity unit;
- Award-winning ICU;
- The Connecticut Spine and Pain Center, which is the only CARF-accredited, multi-disciplinary pain management program in Connecticut;
- The Connecticut Gastroenterology Institute, a top ranked institute for gastroenterology related clinical trials whose Chief Clinical Investigator has been published in the New England Journal of Medicine;
- Inpatient and outpatient behavioral health services;
- Home care and hospice; and
- Advanced diagnostic imaging department offering the latest in CT/PET, MRI and nuclear medicine.

In addition to Bristol Hospital, BHHCG owns and operates Ingraham Manor, a skilled nursing facility; a 40 member multi-specialty group including a medical foundation, an urgent care center and extensive psychiatric services; ambulance services; as well as community-based facilities including radiology, a wellness center and occupational health and rehabilitation centers.

As of September 30, 2011, the Hospital staffs 843 full-time equivalents ("FTEs"). There are 296 medical staff members.

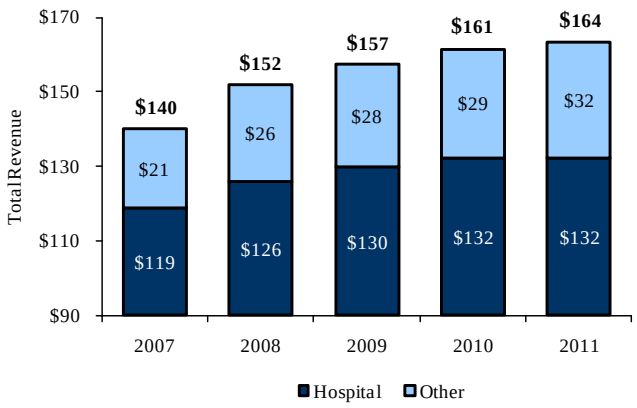
C. Summary Financial and Operating Statistics

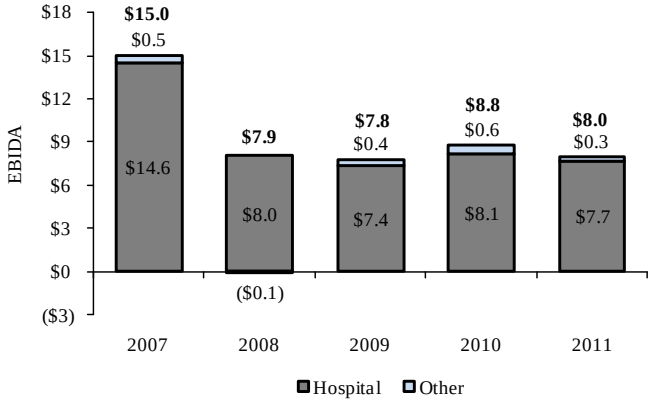
The Hospital, which accounts for 81% of the BHHCG's revenue in fiscal year ending September 30, 2011, has experienced a compounded annual revenue growth rate of 2.7% over the past five fiscal years.

The Hospital also accounted for 96% of BHHCG's EBIDA in FY 2011.

Table 2.1: Summary Operating Results

($ in millions)





Note: Fiscal year ends September 30

Table 2.2: Beds by Service Line

Department	Licenced Beds	Staffed Beds
Medical / Surgical	86	78
Newborn	20	8
Psychiatric	16	14
Maternity	15	15
ICU / CCU	14	14
Pediatric	3	3
Total	**154**	**132**

Table 2.3: Key Hospital Utilization Statistics

	2008	2009	2010	2011
Licensed Beds	154	154	154	154
Staffed Beds	115	132	132	132
Total Admissions	8,019	7,858	7,611	7,302
Average Length of Stay	4.1	4.3	4.0	3.9
Discharges	8,016	7,846	7,617	7,299
Patient Days	33,258	33,658	30,673	28,646
Births	649	591	634	567

Note: Fiscal year ends September 30

Table 2.4: BHHCG Summary Financial Information

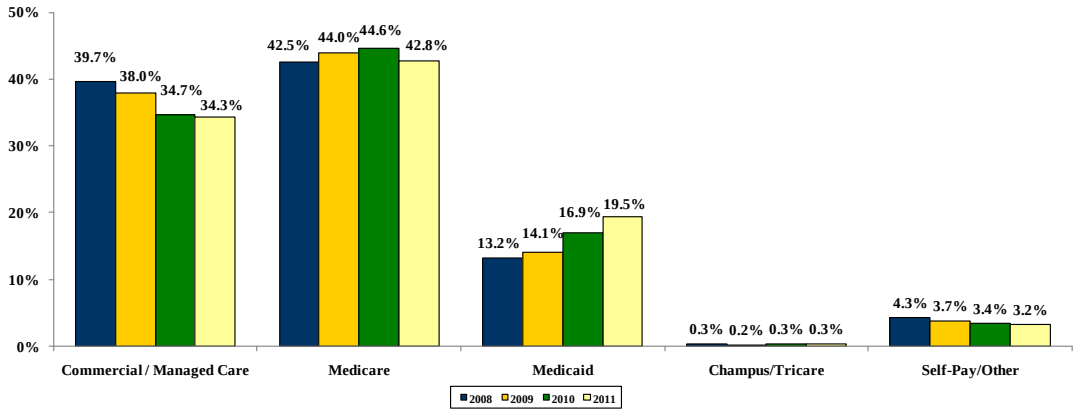
($ in millions)

	FY Ended September 30,				
	2007	2008	2009	2010	2011
Total revenue	$140.0	$151.9	$157.4	$161.5	$163.6
Total operating expenses	143.8	152.7	157.8	160.5	164.0
EBIDA	15.0	7.9	7.8	8.8	8.0
Operating income [(1)]	8.5	1.6	1.9	2.9	1.7
Excess of revenue over expenses	7.5	(1.6)	0.0	1.6	1.7
Capital Expenditures	6.3	2.5	3.0	8.0	9.5

Note: Fiscal year ends September 30
(1) Excludes interest expense

The Hospital's payor mix has remained relatively steady since 2008. The Hospital's historical payor mix is as follows:

Table 2.5: Bristol Hospital Historical Payor Mix (by Gross Revenue)



Note: Fiscal year ends September 30

The Hospital's payors are comprised primarily of Commercial/Managed Care and government payors including Medicare and Medicaid.

- **Commercial/Managed Care.** The Hospital has contracts with five major commercial payors including Aetna, Anthem, Cigna, ConnectiCare and United Healthcare that account for about 34% of the Hospital's payor mix. Anthem has been the largest and comprises over 50% of the commercial business though its share has been dropping as groups switch their health care coverage to other payors.
- **Medicare.** The Hospital's Medicare revenues are generated through both traditional and managed care programs. Medicare comprises about 43% of the Hospital's payor mix. As the population continues to age, the Hospital expects to see a continuing increase in Medicare's portion of the payor mix.
- **Medicaid.** The Hospital's Medicaid revenues are generated through both traditional and managed care programs. Overall, Medicaid comprises about 20% of the Hospital's payor mix.
- **Champus/Tricare.** The Hospital's Champus/Tricare payors account for less than one percent of the payor mix.
- **Self Pay/Other.** The uninsured patient population and worker's compensation comprise about three percent of the Hospital's payor mix.

Table 2.6: Bristol Hospital Utilization Statistics

	For the Fiscal Years Ended September 30,			
	2008	**2009**	**2010**	**2011**
Licensed Beds	154	154	154	154
Staffed Beds	115	132	132	132
Total Admissions	8,019	7,858	7,611	7,302
Average Length of Stay	4.1	4.3	4.0	3.9
Discharges	8,016	7,846	7,617	7,299
Patient Days	33,258	33,658	30,673	28,646
Births	649	591	634	567
Percent of Occupancy - Staffed Beds	79.23%	69.85%	63.66%	59.46%
CT Scans				
Inpatient	3,992	3,998	4,531	2,789
Outpatient	10,172	10,678	10,524	9,338
Total	14,164	14,676	15,055	12,127
MRI Scans				
Inpatient	476	394	375	345
Outpatient	3,029	3,157	3,090	2,807
Total	3,505	3,551	3,465	3,152
PET Scans				
Outpatient	545	363	244	201
Surgical Procedures				
Inpatient	1,468	1,536	1,393	1,429
Outpatient	4,454	3,969	3,695	3,224
Total	5,922	5,505	5,088	4,653
Endoscopy Procedures				
Inpatient	552	576	573	498
Outpatient	2,065	1,878	2,035	2,008
Total	2,617	2,454	2,608	2,506
Emergency Room Visits				
Treated and Admitted	5,723	5,501	5,467	6,177
Treated and Discharged	34,410	33,551	33,293	36,062
Total	40,133	39,052	38,760	42,239
Total Case Mix Index	1.08	1.09	1.08	1.09
Full-Time Equivalents	878	883	842	843

Table 2.7: Historical Procedure Mix – Inpatient Cases from Primary Service Area

	For the Fiscal Years Ended September 30,		
	2008	**2009**	**2010**
Pulmonary	849	839	777
Cardiology	561	652	560
Gastroenterology	549	509	553
Psychiatry	456	462	548
Obstetrics	498	437	450
Newborn	475	439	438
Addiction	271	245	242
General Surgery	235	264	223
Orthopedics	313	254	221
Neurology	202	234	197
Colorectal & Bariatric Surgery	118	127	150
Urology	118	115	102
Gynecology	139	109	101
Ortho Misc Bone & Joint	94	93	100
Allergies & Poisonings	81	77	83
Cardiovascular	81	93	76
Infectious Disease	79	74	76
Oncology & Oncology Surgery	79	74	76
Nephrology	109	99	62
Hematology	85	71	52
ENT	41	31	38
Spine	20	40	38
Miscellaneous	43	36	38
Thoracic Surgery	30	30	32
Trauma - Non Specific	13	18	14
Trauma	6	10	6
Opthalmology	5	6	2
Neurosurgery	11	7	-
Total Cases	**5,561**	**5,445**	**5,255**

Source: Company Reports
Note: Data from 2011 is unavailable

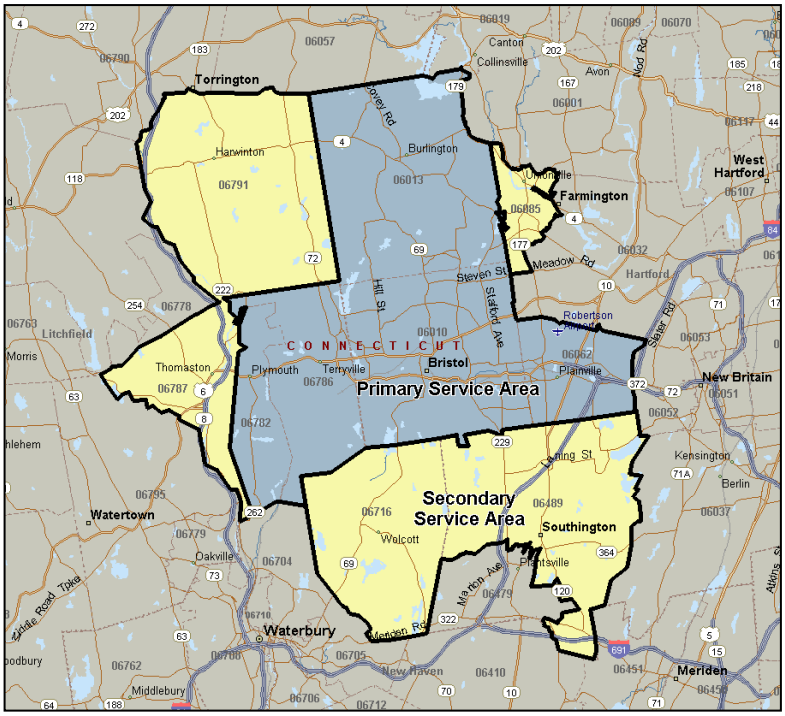
III. Service Area Profile

The Hospital's primary service area, with a total population of approximately 100,000, includes three towns in Hartford County: Bristol, Burlington and Plainville and one town in Litchfield County: Plymouth. 92 percent of Bristol Hospital inpatient discharges from the service area are from the primary service area. Residents of the City of Bristol account for approximately 74% of inpatient discharges from the service area.

Bristol is known as "Bell City" because of a history of manufacturing innovative spring-driven doorbells and the "Mum City" because it was once a leader in chrysanthemum production and still holds an annual Bristol Mum Festival. The City of Bristol is conveniently located in the center of the state and is close proximity to other cities including Hartford, New Haven and Waterbury. In 2010 the city was ranked 84th in the CNN Money 2010 Top 100 Places to Live. Bristol is primarily known as the home of ESPN, whose central studios are in the city and is the largest employer in Bristol. ESPN employees are young with more than half of the employees under the age of 30. ESPN is committed to making the Bristol community stronger and healthier through education and parks and recreation. The City of Bristol is home to the country's oldest continuously operating amusement park, Lake Compounce. Bristol has the national clock museum and is the clock capital of the world. Bristol Hospital is the second largest employer in Bristol and the overall economic, employment and government revenue impacts of Bristol Hospital on Hartford County and the State of Connecticut are significant.

The secondary service area is made up of five towns in Hartford County, Litchfield County and New Haven County. The towns include: Farmington, Southington, Wolcott, Thomaston and Harwinton. Combined, secondary market towns account for approximately 8% of all inpatient discharges from the service area.

Table 3.1: Bristol Hospital Service Area Map



A. Demographics

The Hospital is located in the City of Bristol, the eleventh largest city in Connecticut. The City of Bristol has over 60,000 residents, with the gender breakdown approximately an even split (51.5% female / 48.5% male). The City is also relatively young with a median age of 39.6 years.

Bristol is primarily known as the home of ESPN, whose central studios are in the city and is the largest employer in Bristol. ESPN employees are young with more than half of the employees under the age of 30. ESPN is committed to making the Bristol community stronger and healthier through education and parks and recreation. The City of Bristol is home to the country's oldest continuously operating amusement park, Lake Compounce. The city is also home to a public school system that is consistently ranked among the top in Connecticut. Bristol Hospital is the second largest employer in Bristol and the overall economic, employment and government revenue impacts of Bristol Hospital on Hartford County and the State of Connecticut are significant.

The racial breakdown of the City of Bristol is predominantly white/Caucasian, with a small minority of African Americans and Asians. Hispanic or Latino as a country of origin, which includes many of the races described below is 8.1% of the population. The median household income of the City of Bristol is approximately $58,000. The most recent unemployment rate of the City of Bristol was lower than the national trend, at 7.1%.

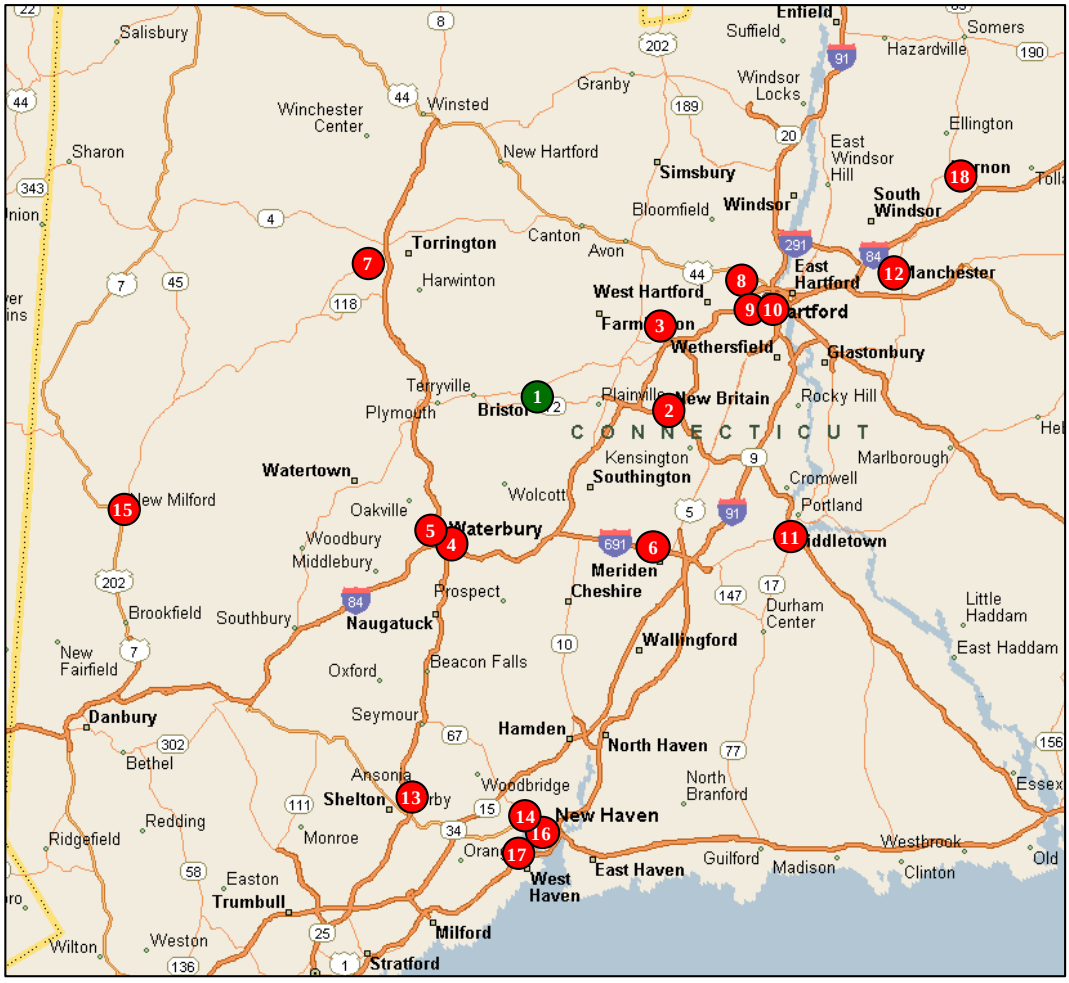
Table 3.2: Market Demographics

	City of Bristol	
Male	29,518	48.5%
Female	31,351	51.5%
Total population	60,869	100.0%
Age		
0-19 years	14,369	23.6%
20-54 years	31,134	51.1%
55-84 years	13,933	22.9%
85+ years	1,433	2.4%
Median age	39.6	
Race[(1)]		
White	53,315	87.6%
Black or African American	2,165	3.6%
American Indian and Alaska Native	163	0.3%
Asian	1,117	1.8%
Other	2,405	4.0%
One race	59,165	97.2%
Two or more races	1,704	2.8%
Median household income	$57,781	
Mean household income	$69,076	
High school degree or higher	86.1%	
Unemployment rate	7.1%	
Industry of employed over 16 years of age		
Agriculture, forestry, fishing and hunting and mining	41	0.1%
Construction	2,285	7.2%
Manufacturing	5,117	16.1%
Wholesale trade	997	3.1%
Retail trade	3,479	10.9%
Transportation and warehousing and utilities	1,222	3.8%
Information	1,353	4.3%
Finance and insurance, real estate, rental and leasing	3,041	9.6%
Professional, scientific, and management and administrative & waste management services	2,311	7.3%
Educational services and health care & social assistance	7,297	22.9%
Arts, entertainment, recreation, accommodation and food services	2,360	7.4%
Other services, except public administration	1,384	4.4%
Public administration	925	2.9%
Total	31,812	100.0%

Source: U.S. Census Bureau, 2005-2009 American Community Survey
(1) Hispanics may be of any race, so also are included in applicable race categories

B. Competition

Table 3.3: Competitive Landscape



Facilities	
1) Bristol Hospital	10) Hartford Hospital
2) The Hospital of Central Connecticut	11) Middlesex Hospital
3) University of Connecticut Health Center	12) Manchester Memorial Hospital
4) Saint Mary's Hospital	13) Griffin Hospital
5) Waterbury Hospital	14) Hospital of Saint Raphael
6) MidState Medical Center	15) New Milford Hospital
7) The Charlotte Hungerford Hospital	16) Yale-New Haven Hospital
8) Saint Francis Hospital and Medical Center	17) Veterans Affairs Connecticut Healthcare System
9) Connecticut Children's Medical Center	18) Rockville General Hospital

The Hospital's primary competitors are considered:

The Hospital of Central Connecticut – located eight miles away from the Hospital, The Hospital of Central Connecticut is a 446-bed acute-care community teaching hospital with campuses in New Britain and Southington, Connecticut. It was created with the 2006 merger of the former New Britain General Hospital and Bradley Memorial Hospital. The Hospital of Central Connecticut provides comprehensive inpatient and outpatient services in general medicine and surgery and a wide variety of specialties including the Endocrine and Bone Health Center, Cancer Services, Cardiology, Clinical Research, Family BirthPlace, Joslin Diabetes Center Affiliate, Joint and Spine Center, Psychiatry and Behavioral Health, Sleep Disorders Center, Vascular Center, Center for Bariatric Surgery, Weigh Your Options Weight Loss Center, Wolfson Palliative Care and Wound Care Center. The Hospital of Central Connecticut is affiliated with the University of Connecticut School of Medicine and participates in residency programs. The Hospital of Central Connecticut is a member of the Central Connecticut Health Alliance, a system of health care affiliates that provides a wide array of services throughout the region.

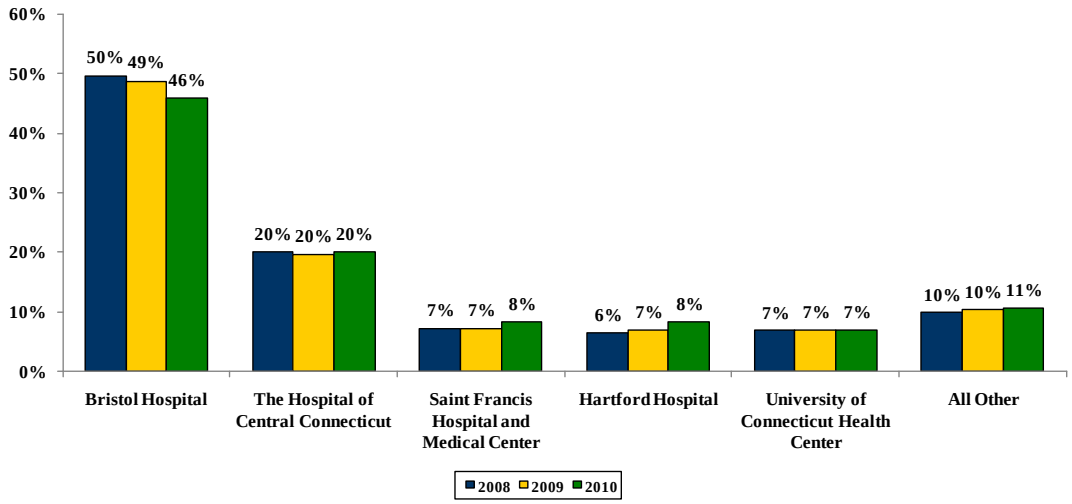
Saint Francis Hospital and Medical Center – located 14 miles away from the Hospital, Saint Francis Hospital and Medical Center is a 617-bed integrated healthcare delivery system located in Hartford, Connecticut. It is a major teaching hospital affiliated with the University of Connecticut Schools of Medicine and Dental Medicine and the largest Catholic hospital in New England. Centers of excellence include The Hoffman Heart and Vascular Institute of Connecticut, The Saint Francis/Mount Sinai Regional Cancer Center, Mount Sinai Rehabilitation Hospital, The Connecticut Joint Replacement Institute, New Beginnings Family Birth Care Center and Comprehensive Breast Health Center. Care Centers include Diabetes Care Center, Bariatric Center, Joyce D. and Andrew J. Mandell Center for Comprehensive Multiple Sclerosis Care and Neuroscience Research, Stroke Center, Center for Advanced Wound Healing and Lymphedema, The Hartford Regional Lead Treatment Center, The Aetna Foundation Children's Center and Connecticut VNA Partners.

Hartford Hospital – located 14 miles away from the Hospital, Hartford Hospital is a 867-bed, not-for-profit regional tertiary medical center in Hartford, Connecticut. Hartford Hospital's major centers of excellence include Helen & Harry Gray Cancer Center, Henry Low Heart Center, Stroke Center, Women's Health Services, Joint Center, Spine Center, Robotic Surgery, Minimally Invasive Surgery, Transplantation, Bariatric Surgery, The Institute of Living, Gastroenterology and Colorectal Surgery. Hartford Hospital is the major teaching hospital affiliated with the University of Connecticut School of Medicine and is a major teaching site for nurses and allied health professionals. Hartford Hospital performed the first successful heart transplant in the state and pioneered the use of robotics in surgery. Hartford Hospital owns and operates the state's only air ambulance system, LIFE STAR and is Hartford's only Level 1 Trauma Center.

University of Connecticut Health Center – located eight miles away from the Hospital, University of Connecticut Health Center is a 224-bed academic medical center based in Farmington, Connecticut. University of Connecticut Health Center is home to the School of Medicine, School of Dental Medicine, John Dempsey Hospital, UConn Medical Group, UConn Health Partners, University Dentists and a research enterprise. John Dempsey Hospital provides specialized and routine inpatient and outpatient care services and is widely recognized for its excellence in maternal fetal medicine, cardiology programs, cancer care and orthopedics. In 2011, the Connecticut General Assembly passed the Bioscience Connecticut initiative that includes renovations to the Health Center's research tower and the construction of a new patient tower and a new ambulatory care facility. In addition, the plan calls for increase of the Schools of Medicine and Dental Medicine enrollment by 30 percent.

Bristol Hospital has a strong market position in its PSA with 46% of the total PSA volume.

Table 3.4: Top 5 Primary Service Area Competitors (1)



Source: CHIME Database
Note: Fiscal year ends September 30; Data from 2011 is unavailable
(1) Excludes observations; may significantly impact discharge/market share data by "shifting" status of patients between 2008 and 2010

IV. Appendices

Appendix A – 2011 BHHCG Audited Financials

See Separate PDF© File

Appendix B – 2011 Hospital Audited Financials

See Separate PDF© File

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CAIN BROTHERS & COMPANY, LLC

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 3: SUMMARY OF RFP RESPONSES

Confidential Discussion Materials

January 30, 2012

Process Update - CONFIDENTIAL

Introduction

Bristol Hospital and Health Care Group, Inc. ("Bristol") engaged Cain Brothers & Co. ("Cain Brothers") on October 11, 2011 to lead the search for a strategic and/or capital partner

- After several meetings with Bristol's Partnership Committee and Executive Management Team ("Management"), Cain Brothers, along with Bristol's Counsel, developed strategic goals and objectives, a strategic marketing process, as well as marketing materials
- Under the Partnership Committee's direction, Cain Brothers was asked to start marketing calls to a predetermined Tier I partnering list of ten organizations consisting of:
  - Three (3) tax-exempt hospital organizations
  - Six (6) investor-owned hospital operators
- These organizations were perceived to have a combination of financial and operational wherewithal to achieve Bristol's stated goals and objectives
- These marketing calls began on January 3, 2012 and concluded with a deadline for submissions of Preliminary Indications of Interests ("IOIs") on January 20, 2012

Process Update - CONFIDENTIAL

Solicitation Process

For the past three weeks, Cain Brothers worked with Management and Counsel to help facilitate the solicitation process of the ten (10) potential partners

- Nine (9) parties requested non-disclosure agreements ("NDAs") to participate in the process
  - Five (5) were sent to investor-owned; three (3) to tax-exempt; (1) to
- All nine executed the NDA
- Four (4) organizations decided to submit an IOI at the deadline
  - Two (2) investor-owned
  - One (1) tax-exempt

Process Update - CONFIDENTIAL

Parties Who Declined/Unresponsive

Six (6) organizations contacted declined or were unresponsive to pursue a strategic partnership / acquisition

Tax-Exempt Organizations

Organization	Reasons for Decline / Unresponsive
	▪ Decided to focus on their internal strategic processes ▪ Couldn't dedicate the necessary time and resources
)	▪ Focused on other business relationships ▪ Interested in extending a Network Membership to Bristol Hospital

Taxable Organizations

Organization	Reasons for Decline / Unresponsive
)	▪ Not interested in the opportunity; outside its core competency
	▪ Bristol market is too competitive and would not have gotten any leverage from their Sharon operations
	▪ Unresponsive as of the date of the presentation
	▪ Not a strategic fit

Note: Italicized organizations signed confidentiality agreements.

BRISTOL HOSPITAL

Process Update - CONFIDENTIAL

Summary of Indications of Interest – Tax Exempt / Public Entity

Overview	▪ Integrated health care delivery system providing care in over locations ▪ Strategy to develop integrated delivery system through alliances with community hospitals, not necessarily acquisitions ▪ Currently in the process of finalizing a relationship with	▪ Integrated academic medical center whose mission includes academics, research and clinical care ▪ ▪ Has numerous affiliations of many different types
Activities in Connecticut		
Potential Conflicts		▪ None specified,
Primary and Secondary Market Discussion	▪ No competitive clinical services that operate within Bristol's defined primary market ▪	▪ ▪ Opportunity to improve the regional standard of care by aligning the clinical care continuum
Opportunities for Growth	▪ An accountable care organizational structure that provides opportunities for a wide range of clinical integration options ▪ Need to identify opportunities for enhanced service offerings, strategic capital needs and any associated physician recruitment needs during diligence	▪ High outmigration of surgical inpatients from Bristol in cardiology and orthopaedics ▪ Cardiology and orthopaedics representing significant opportunities ▪ Key growth service lines including orthopaedic services, vascular services and thoracic surgery
Proposed Governance and Organizational Structure	▪ Member Substitution ▪ appoints two additional members to existing BHHCG Board; to select replacement Bristol Board in future ▪ would have approval rights for any major action from Bristol's Board ▪ BHHCG offered a seat on the Board ▪ Willing to consider alternative structures	▪ None specified ("A number of possible structures") ▪ Reflect the key elements of the affiliation developed as well as the associated needs of each organization ▪ Develop alongside the clinical and financial affiliation plans

BRISTOL HOSPITAL

Process Update - CONFIDENTIAL

Summary of Indications of Interest – Investor Owned

		VANGUARD HEALTH SYSTEMS
Overview	▪ Established to provide essential capital and expertise to NFP hospitals and health systems ▪ Looks for opportunities to link facilities together into strong regional networks ▪ hospitals in states,	▪ 28 hospitals with related businesses in six markets ▪ Has invested over $1 billion in its markets since 2004 ▪ 5 year capital commitment, needs will be assessed during diligence ▪ Develop a capital program that enhances the existing assets and expands the services lines
Activities in Connecticut		▪ Actively pursuing multiple opportunities ▪ Intend to strategically align and connect facilities both within the state and northward into Massachusetts ▪ Intend to create academic relationships within Connecticut
Potential Conflicts	▪ No conflicts are mentioned,	▪ None
Primary and Secondary Market Discussion		▪ In process of developing Connecticut as one of its focus markets ▪ Activity will ultimately enhance and support Bristol's operations in its service areas
Opportunities for Growth	▪ Extensive specialty and subspecialty coverage can be very helpful in Bristol to develop new service lines and fills gaps in the Bristol medical staff ▪ Continuing access to capital for growth and expansion	▪ Create a local operating division maintaining local branding, governance and community ownership ▪ Allows BHHCG to leverage the scale of a national company and the support and collaboration of its regional New England market
Proposed Governance and Organizational Structure	▪ JV or asset purchase ▪ JV: 60-80% / 20-40% Bristol ▪ Asset purchase: 80% / 20% Unnamed Regional Partner ▪ JV Board of 50% / 50% Bristol or Regional Partner ▪ Hospital Board community leaders / physicians	▪ Taxable JV or asset purchase ▪ Flexible regarding specific ownership percentages and governance, although Bristol would take a minority position ▪ Hospital Board would have 50% physicians

BRISTOL HOSPITAL

Process Update - CONFIDENTIAL

IOI Concerns

Of the four (4) non-binding proposals, each has a series of questions and concerns that should be addressed

Tax-Exempt

Organization	Questions / Concerns
	▪ Proposed structure cedes Bristol control
	▪ Uncertainty of transaction structure ▪ Uncertainty of access to capital ▪ , uncertainty of ability to close a transaction

Taxable Organizations

Organization	Questions / Concerns
	▪ Capital "dry powder" given pending new hospitals in ▪ Ability to handle ▪ Conversion process
Vanguard Health Systems (Nashville, TN)	▪ No presence currently in Connecticut ▪ Conversion process

Process Update - CONFIDENTIAL

Recommendations and Next Steps

The Partnership Committee needs to select parties to continue on to Phase II

- Today - select parties to continue to Phase II
  - Consists of detailed due diligence and is intended to provide the information that a qualified respondent will need in order to submit a binding proposal
  - Access to a Bristol virtual data room, site visits and management discussions
  - Beginning the week of January 30 and lasting three weeks
  - Non-binding proposals due February 17
- Phase III consists of receiving binding, definitive proposals, which will be due following the completion of the Phase II due diligence process
  - It will include a markup of a Definitive Agreement to be provided by Bristol prior to submission of the binding proposal
- Please remember, Bristol has no obligation to accept any proposal, whether or not such proposal represents the best offer
  - Until such time that a Definitive Agreement has been executed, Bristol will not have any obligation to any potential partner with respect to any transaction involving Bristol

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 4: COMPARISON OF PROPOSALS

Confidential Discussion Materials

April 25, 2012

Overview of Proposals

Summary of Indications of Interest

		VANGUARD HEALTH SYSTEMS	
Form of Transaction	▪ Taxable Joint Venture ("NewCo") where would own 60-80% of NewCo, BHHCG or its surviving entity would own 20-40%	▪ 100% Asset Purchase	▪ Preferred strategic affiliation ▪ Exclusive renewable arrangement with a term of at least 10 years
Post Transaction Structure	▪ New for-profit JV created that acquires and operates hospital ▪ JV (new hospital) owned 80% – 20% by BH ▪ BH remains a not-for-profit with ability to make additional investments in the JV that operates the hospital and fund other community health needs.	▪ Vanguard acquires and operates hospital as new for-profit CT corp. ▪ BH becomes an independent not-for-profit Community Foundation that cannot support new hospital operations	▪ Affiliation between and BHHCG ▪ would determine governance structure ▪ BH continues to own and operate hospital
Board Membership	▪ JV board – 10 directors 5 appointed by BH, 5 appointed by (includes 2 local MDs) ▪ New hospital board – 12 directors appointed by JV. 6 MDs and 6 community members. ▪ BH board – unchanged – BHHCG elects board	▪ New hospital board-appointed by Vanguard: 50% local physicians, 50% community reps, and hospital CEO. Will consider appointments from current BH board ▪ Community Foundation board-directors must be independent. No former director of BH or Vanguard or affiliate boards.	▪ BH and affiliate boards - appoints some directors (<50%) ▪ BHHCG board – appoints 3 directors ▪ board – BHHCG nominates one director ▪ Integrated management organizational structure

Overview of Proposals

Summary of Indications of Interest

		VANGUARD HEALTH SYSTEMS	
Board Rights	▪ JV board – approval of: addition/ termination of services; capital and operating budgets; cash distributions; hiring CEO. BH reserve powers: name JV Chair; terminate JV CEO; dissolve JV if not meet IRS rules. ▪ New hospital board – approves medical staff credentialing; QA; strategic planning; mission, vision, and value statement; id new service opportunities	▪ New hospital board – limited to med staff credentialing, QA and accreditation. Reviews and recommends strategic and capital plans. Provides guidance on local issues.	▪ BHHCG and affiliate boards – modify role of corporators (not identified) ▪ Provide certain rights (not defined) re strategic planning, budgets, new programs, medical education, fundamental changes, material agreements.
BH Control Over Change in Service	▪ Yes – as long as 20% equity interest in JV retained ▪ Proportional voting below 20% and right to call remaining BH interest	▪ Only indirect through advisory role and CON process	▪ Yes
BH Control Over Restricted Charitable Assets	▪ Yes – subject to AG approval	▪ No	▪ Yes
Role of BH Affiliates	▪ JV would own and operate all BHHCG entities except BHDF ▪ BHDF could continue (or be into BHHCG) and through investments in JV support new for-profit hospital subject to AG approval	▪ Acquisition of all BHHCG operations except for BHDF ▪ BHDF may no longer support new for-profit hospital operations	▪ BHHCG, BH, BHMSG, and BHDF retain current legal status ▪ No changes to BH affiliates identified other than representation on the governing boards (<50%) and certain rights described above

BRISTOL HOSPITAL

Overview of Proposals

Summary of Indications of Interest

		VANGUARD HEALTH SYSTEMS	
Proposed Transaction Value	▪ $62 to $67 million	▪ $60 to $80 million	▪ None Provided
Potential Net Cash Proceeds (1)	▪ To BHHCG or its surviving entity: ($1.3) to $1.5 million (2)	▪ To independent community foundation: $18.8 to $37.8 million	▪ N/A
Capital Expenditure Commitments and Funding Source	▪ $40 million available at closing ▪ Multiple sources of capital options including cash-flow from operations and debt financing ▪ Capital call is highly unlikely and requires approval by the Bristol members of the JV Board	▪ $50 to 70 million over the next 5 years, subject to due diligence, and working with the Board, senior management and medical staff to identify future capital needs ▪ Funding of capital through existing cash and funds available under current Vanguard lines of credit	▪ $10 to $38 million made available by to support stated highest priority capital needs, allocated over the first five years ▪ structured as a loan with as the guarantor, can be accessed for capital investments commensurate with their job impact
Partner's Commitment to Specific Capital Projects	▪ agrees with the general priorities of private rooms, physical access to facility and ER expansion ▪ Subject to additional due diligence	▪ Vanguard agrees with the general priorities of private rooms, physical access to facility and ER expansion ▪ Subject to additional due diligence	▪ Expect capital needs relating to physician recruitment and operational/quality initiatives to be lessened by the affiliation ▪ Subject to additional due diligence
Long-Term Liabilities	▪ Long-Term Tax-Exempt Debt: Extinguished through cash proceeds and existing assets ▪ Pension Liabilities: Will not assume; will need to be terminated through cash proceeds and existing assets	▪ Long-Term Tax-Exempt Debt: Extinguished through cash proceeds and existing assets ▪ Pension Liabilities: Assumed for a dollar-for-dollar reduction in cash purchase price for underfunded portion	▪ Long-Term Tax-Exempt Debt: Assist Bristol in refinancing its $30 million debt as guarantor or co-obligor; Provide funding for operating losses, to the extent necessary, to service Bristol's debt obligations (3) ▪ Pension Liabilities: Remains in place
Continuation of Services	▪ No change in services without the approval of the Bristol members of the JV Board	▪ Willing to commit not to eliminate any core service for 10 years, to be defined by management and Vanguard during diligence process	▪ Anticipate that all current clinical services would be maintained ▪ Bristol to pay an affiliation fee and profit-share with a joint affiliation fund for services

(1) Based on Cain Brothers estimates and discussions with buyers. See following pages for calculations.
(2) Assumes BHHCG has a 20% interest in JV.
(3)) Maximum funding for obligations and form of funding to be specified in agreement.

Overview of Proposals

Summary of Indications of Interest

		VANGUARD HEALTH SYSTEMS	
Expansion of Services	▪ Any change in service levels would require approval of the Bristol members and members of the JV Board of Directors ▪ Service line development in areas such as orthopedics and neurology	▪ Develop a comprehensive orthopedic, thoracic and vascular surgery program ▪ Work with management, medical staff and Board of Trustees to identify opportunities	▪ Recruitment of 15 additional MDs located at strategic sites within the Bristol area to serve the Bristol community ▪ Ability to realize operational savings and growth of clinical services
Excluded Activities and Operations	▪ intends to include all existing activities and operations, except for the Bristol Hospital Development Foundation	▪ Vanguard intends to include all existing activities and operations, except for the Bristol Hospital Development Foundation	▪ to include all activities
No Sale	▪ would commit not to sell its interest in NewCo for 5 years	▪ Vanguard has commitment to provide services for 10 years ▪ In the past 15 years, Vanguard has sold only its California operations (3 locations) as a strategic decision to leave the state	▪ Ownership retained by BHHCG
Right of First Refusal / Repurchase Rights	▪ Non-selling JV party will have a "First Right of Refusal"	▪ Open for discussion	▪ Bristol will not affiliate with another health care organization during the term of the affiliation
Employee Matters	▪ All employees, management and physicians will remain, subject to diligence and will be employed by the Joint Venture	▪ All employees, management and physicians will remain, subject to diligence and will be employed by Vanguard	▪ All employees, management and physicians will remain, subject to diligence, and will be employed by BHHCG ▪ Certain key executive, departmental leadership roles may be converted to employment status based on strategic alignment by both parties

BRISTOL HOSPITAL

Overview of Proposals

Summary of Indications of Interest

		VANGUARD HEALTH SYSTEMS	
Charity Care Commitment	▪ No changes to existing charity care expected	▪ No changes to existing charity care expected	▪ No changes to existing charity care expected
Partner's Financial Capacity	▪ Well capitalized with an equity commitment from its financial sponsors, ▪ Has a credit facility from a lending group to fund future growth as needed	▪ Strong equity and capital markets sponsorship ▪ Completed IPO primary private equity partner ▪ Has secured credit facilities to finance capital	▪ Three sources of capital:
Potential Partner's Hospital Management Capability	▪ is relatively young company ▪ Current executive team has extensive experience developing and operating hospitals; developed JVs with not-for-profit partners including ▪ current and pending JVs	▪ Founded in 1997, Vanguard has operating and owned hospitals in six large markets for the past 15 years ▪ Currently owns and operates 28 hospitals with over 6,200 licensed beds ▪ Also forming JVs with not-for-profit systems in urban and related suburban markets to further develop regional, integrated healthcare networks	▪
Regulatory Reviews/Issues	▪ CON, AG, FTC (possibly) ▪ Proceeds to BH must receive fairness evaluation ▪ AG must confirm continued use of restricted donations	▪ CON, AG, FTC (possibly) ▪ Proceeds to Community Foundation must receive fairness evaluation ▪ Community Foundation funds cannot support future hospital operations ▪ Community Foundation board must be independent	▪ CON

Overview of Proposals

Summary of Indications of Interest

		VANGUARD HEALTH SYSTEMS	
Other Considerations	▪ Young organization with nascent hospital management support infrastructure/relatively unproven track record ▪ Strength is shared ownership/governance model ▪ Unclear long term strategy for success in CT market, ▪ Private equity exit strategy/relatively short (5 year) no sale commitment ▪ Additional tax cost to operations ▪ Management fee of 2% of JV net revenue off the top ▪ Potential for "creeping full acquisition" if future equity capital is necessary	▪ Best financial transaction? ▪ Firmness of capital commitment? ▪ Full for-profit conversion ▪ No continuing governance control ▪ Independent foundation as only continuation of nonprofit health care mission ▪ No current CT presence or network ▪ Other NE facilities do not provide market leverage or strategic positioning – will need CT based tertiary relationship/continuum of care to position for future success ▪ Relatively strong hospital management support infrastructure and experience ▪ No sale commitment probably limited to stand-alone sale ▪ Additional tax cost to on-going operations	▪ Permanence/legacy ▪ Vagueness of capital commitment ▪ Established network of providers and elements of care continuum ▪ Clinical programmatic opportunities

Overview of Proposals

Net Cash Proceeds Analysis –

($ in millions)

Total Value of Assets	**$62.0**	–	**$67.0**
Estimated Cash Dividend to BHHCG from JV [1]	**$41.6**	–	**$45.6**
Less:			
Accrued Payroll and Other Accrued Expenses not Assumed by JV	(6.4)		(6.4)
Extinguishment of Long-Term Debt (including penalities if any)	(36.8)		(36.8)
Other Accrued Liabilities Not Assumed by JV	(4.6)		(4.6)
Funding of Pension & Retirement Obligations by BHHCG	(33.6)		(33.6)
Termination Cost of Pension Obligations [2]	(0.3)		(0.4)
Transaction Costs [3]	(2.0)		(3.0)
Plus:			
Cash and Cash Equivalents	9.1		9.1
Short-Term Investments	0.1		0.1
Other Receivables	0.8		0.8
Estimated Settlements Due from Third-Party Payers	2.4		2.4
Prepaid Expenses	0.3		0.3
Debt Service Funds	0.7		0.7
Assets Whose Use is Limited	23.2		23.2
Other Assets [4]	4.3		4.3
Total Adjustments	(42.9)		(44.1)
Net Cash Proceeds to BHHCG	**($1.3)**	–	**$1.5**

Note: Reflects September 30, 2011 BHHCG financial statements.
(1) Does not include the value of the 20% interest in JV.
(2) Estimated by BHHCG management.
(3) Estimated by Cain Brothers.
(4) Assumes 50% cash value.

BRISTOL HOSPITAL

Overview of Proposals

Net Cash Proceeds Analysis – Vanguard

($ in millions)

Purchase Price (Cash):	**$60.0**	–	**$80.0**
Less:			
Extinguishment of Long-Term Debt (including penalities if any)	(36.8)		(36.8)
Other Accrued Liabilities Not Assumed	(9.3)		(9.3)
Purchase Price Reduction due to Pension & Retirement Obligations	(33.6)		(33.6)
Transaction Costs [(1)]	(2.0)		(3.0)
Plus:			
Cash and Cash Equivalents	9.1		9.1
Short-Term Investments	0.1		0.1
Other Receivables	0.8		0.8
Estimated Settlements Due from Third-Party Payers	2.4		2.4
Debt Service Funds	0.7		0.7
Assets Whose Use is Limited	23.2		23.2
Other Assets [(2)]	4.3		4.3
Total Adjustments	(41.2)		(42.2)
Net Cash Proceeds to Community Foundation	**$18.8**	–	**$37.8**

Note: Reflects September 30, 2011 BHHCG financial statements.
(1) Estimated by Cain Brothers.
(2) Assumes 50% cash value.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 5: LETTER OF INTENT

LETTER OF INTENT

This Letter of Intent (this "*LOI*") is made effective as of the ___ day of November, 2012 (the "*Effective Date*") by and among **Bristol Hospital & Health Care Group, Inc.,** a non-profit, tax exempt corporation incorporated under the laws of the State of Connecticut with a principal place of business at 41 Brewster Road, Bristol, CT 06010, on behalf of itself and its affiliates ("*BHHCG*" or "*Seller*"), and **Vanguard Health Systems, Inc.**, a for-profit corporation incorporated under the laws of the State of Delaware with a principal place of business at 20 Burton Hills Boulevard, Suite 100, Nashville, TN 37215 ("*Vanguard*" and, together with BHHCG, the "*Parties*").

In consideration of the mutual covenants and agreements hereinafter expressed, the Parties agree as follows with respect to the transactions contemplated by this LOI (the "*Transactions*"):

1. **Form of Transaction.** The purpose of this LOI is to set forth certain non-binding understandings and certain binding agreements by and between BHHCG, as Seller, and a subsidiary of Vanguard designated by Vanguard ("*Buyer*"), as Buyer, pursuant to which BHHCG intends to sell substantially all of its assets and operations to Buyer, including the assets of BHHCG, Bristol Hospital, Inc., Bristol Hospital Multispecialty Group, Inc., EMS, LLC, Bristol Health Care, Inc., including its subsidiary Ingraham Manor (collectively, the "*Business*"), together with Seller's joint venture interests in Bristol MSO, LLC (50%), Medworks, LLC (49%), Connecticut Occupational Partners (33%), MedConn Collection Agency (20%), Total Laundry Cooperative, LLC (9%), Central Connecticut Endoscopy Center, LLC (6.5%), and Health Connecticut, LLC (5.4%) (collectively, the "*JV Interests*"). After the Closing (as defined below), Buyer will operate Bristol Hospital as a for-profit hospital (the "*Hospital*"), and one or more for-profit entities will operate the remainder of the Business (each a "*NewCo*").

(a) **Purchased Assets**. The assets and operations of the Business to be acquired by Buyer in connection with the Transactions include all assets owned, leased or licensed by Seller that are used in the operation of the Business, except for Excluded Assets (as defined below), including real property used in connection with the operation of the Business, or acquired for the benefit of the Business, including any buildings, leaseholds, improvements or fixtures; equipment; patient, medical, personnel and other records of the Business; licenses and permits (to the extent transferable); trade names (to the extent transferable); the JV Interests; accounts receivable; certain assumable contracts, leases and licenses related to the operations of the Business; interests in all property arising or acquired in the ordinary course of the operation of the Business between the date of this LOI and the Closing (as defined below); inventory and supplies of the Business; prepaid expenses and security deposits that have continuing value to the operation of the Business; all other property, whether tangible or intangible, of every kind, character or description owned by Seller and used or held for use in the operation of the Business; and any other assets owned by Seller which are necessary for the operation of the Business (collectively, the "*Purchased Assets*"). At Closing, Seller will convey good and marketable title to the Purchased Assets to Buyer, free and clear of all liens, encumbrances and defects in title, except for customary covenants, conditions, easements and restrictions of record affecting the real property or that Buyer otherwise chooses to assume in connection with the Transactions.

(b) **Excluded Assets**. The sale of the Business will not include the gifts, grants, bequests, donations, and investment income and other assets of Bristol Hospital Development Foundation, cash, cash equivalents and investments of the Business, receivables from physicians, short-term investments, debt service fund, required and excess funds held under Seller's malpractice self-insurance fund, funds held under bond indenture agreements, Board designated funds, long term investments, amounts that may result from post-Closing settlements of cost reports, appeals and other risk settlements of the Business that relate to pre-Closing periods, assets of the Business whose use is limited or restricted, any self-funded worker's compensation deposit of the Business, deferred expenses, and such other assets of the Business as the Parties may mutually agree in the Definitive Agreements (as defined below) to exclude from the Transactions (collectively, the "*Excluded Assets*").

(c) **Assumption of Liabilities**. Buyer will assume all current liabilities of Seller that are included in the calculation of Net Working Capital (as hereinafter defined); all obligations arising after the Closing under assigned contracts, leases (including capital leases), and licenses; all participating provider agreements and provider numbers with third party payors, including the Hospital's acute hospital Medicare provider number, to the extent such agreements and provider numbers are assignable to Buyer; any pension liability of Seller including any liability of Seller under its frozen defined benefit pension plan, any accrued post-retirement benefit or other retirement obligation owed by Seller; and such other pre-Closing liabilities of the Business that Buyer agrees to assume in the Definitive Agreements (collectively, the "*Assumed Liabilities*"). It is the intent of the Buyer to assume those contracts, leases, and agreements presently utilized in the operation of the Business that are of reasonable and ordinary scope, compensation and duration or are not in violation of federal, state or local laws or regulations.

(d) **Excluded Liabilities**. All liabilities of Seller and the Business that are not Assumed Liabilities shall be retained by Seller (collectively, the "*Excluded Liabilities*"), and Buyer will not assume at Closing, and Seller will remain liable for and indemnify Buyer against, any and all Excluded Liabilities. Excluded Liabilities include, but are not limited to, any line of credit to which Seller is a party, any tax exempt CHEFA bonds issued by Seller, any other indebtedness of Seller, any interest accrued as of the Closing Date on indebtedness of Seller, any settlements due as of the Closing to third party payors, and all medical malpractice and general liability claims that relate to pre-Closing periods.

2. **Purchase Price.** In exchange for the Purchased Assets, subject to confirmatory due diligence on Seller and the Business, Buyer will pay Forty-Five Million Dollars ($45,000,000) plus or minus the amount by which the net book value of Net Working Capital of the Business is greater or less than Net Working Capital of the Business on September 30, 2012 (the "*Purchase Price*"). The Purchase Price less the book value of any capital leases and pension liabilities and other Assumed Liabilities (other than those Assumed Liabilities included in the calculation of the Net Working Capital of the Business) assumed by Buyer shall be paid in cash at Closing. A portion of the Purchase Price will be used by Seller at Closing to defease its CHEFA bonds, pay off its bank debt, retire certain Excluded Liabilities and maintain a reserve for indemnification claims by Buyer for the period specified in Section 11 below. The balance of the Purchase Price (the "*Proceeds*") will be paid by Buyer to an independent tax exempt organization, designated by BHHCG that will invest and use the Proceeds for the benefit of the citizens of Bristol, CT and surrounding communities in accordance with this Section 2 ("*Community Foundation*"). The

Proceeds will be paid at Closing by Buyer to the Community Foundation in cash, by wire transfer or other immediately available funds.

(a) **Community Foundation**. The Community Foundation that receives the Proceeds will not be affiliated with Seller or Buyer through corporate structure, governance or membership. The Definitive Agreements will require that the Community Foundation use the Proceeds for (a) appropriate charitable health care purposes consistent with Bristol Hospital's original purpose, (b) support or promote health care generally in Bristol, CT and its surrounding communities (the "*Community*"), or (c) with respect to donor restricted assets, for a purpose consistent with the donor's intent.

(b) **Fair Market Value**. The Parties have determined the Purchase Price through good faith and arms-length bargaining after Seller has conducted an open bidding process in which reasonable time was allowed for exposure of the proposed sale of the Business in the open market. The Parties expect that the Purchase Price will be confirmed as the fair market value of the Purchased Assets by an independent health care investment banking firm expert in such matters.

(c) **Net Working Capital**. For purposes of this LOI, "Net Working Capital" means all non-cash current assets of the Business acquired by Buyer, including usable inventory and supplies, patient accounts receivable, other receivables, and prepaid expenses and deposits that have continuing value to the operations of the Business, less all current liabilities assumed by Buyer, including trade accounts payable, accrued payroll and other related expenses, advance payments on patient accounts and employee benefit accruals (including accrued vacation and sick time).

3. **Governance and Management**. As of the Closing, Buyer's board of directors will establish a ten (10) member Board of Trustees for the Hospital (the "*Local Board*"). The Local Board will be comprised of four (4) physician members of the Hospital's Medical Staff ("*Medical Staff*"), five (5) community leaders, and the Chief Executive Officer of the Hospital. The initial five (5) community leaders will be selected by mutual agreement of the Parties from among members of the current BHHCG Board of Directors, and will include the current Board Chair (the "*Initial Community Directors*"). The Local Board, which shall serve as an advisory board to Buyer's board of directors, will act by majority vote of its Trustees. For a period of at least five (5) years after Closing, the Initial Community Directors (and their successors), together with a Vanguard appointee, will serve as the nominating committee to nominate candidates to fill expired or vacant Community leadership positions on the Local Board. The nominating committee will act by majority vote of its members.

(a) In general, financial, strategic and other decisions of the Local Board will require approval by Buyer's board of directors, and Buyer's board of directors will have standard reserved powers necessary for the Hospital and Buyer to be a viewed as a single legal entity for antitrust purposes and to qualify for consolidated financial and tax reporting.

(b) The Local Board will be responsible for and provide recommendations to Buyer and its board of directors regarding the establishment of Hospital policies, the maintenance by Hospital of patient care quality and the provision of clinical service and community service

planning in a manner responsive to local community needs. The duties of the Local Board will include, but not be limited to:

(i) Ensure compliance with all accreditation requirements including but not limited to credentialing and other Medical Staff matters;

(ii) Provide oversight for institutional planning, make recommendations for new clinical services, participate in an annual review of, and make recommendations regarding, Hospital strategic and financial plans and goals;

(iii) Review and recommend approval of the Hospital's operating and capital budgets as well as make recommendations with respect to capital expenditures fulfilling capital commitments to the Business made by Buyer in the Definitive Agreements;

(iv) Be responsible for the Hospital's quality assessment and improvement programs;

(v) Provide oversight of Hospital's risk management programs relating to patient care and safety;

(vi) Be responsible for the Hospital's disaster plans that deal with both internal (e.g., fire) and external disasters;

(vii) Evaluate and recommend recruitment needs of the Hospital to ensure adequate medical staff capacity to continue to meet Community needs; and

(vii) Provide guidance and support on local market issues, community concerns and considerations, health care services provided, and related issues and politics.

(c) Buyer agrees that reasonable recommendations of the Local Board will be considered in good faith by Buyer's board of directors.

(d) Buyer will hire the current Chief Executive Officer of the Hospital and assume his existing employment agreement. Seller has provided a copy of the Chief Executive Officer's employment agreement to Buyer as of the Effective Date. Buyer will consult with the Local Board before hiring any successor CEO of the Hospital within five (5) years after Closing.

(e) Vanguard typically delegates to the CEO of its hospitals the authority to hire/fire the management team of those hospitals in consultation with Vanguard, and Buyer would delegate such authority with respect to the Hospital.

(f) Provisions of the Definitive Agreements that implement the above governance and management commitments will not be amended, altered or repealed during the first 5 years after the closing of the Definitive Agreements without the prior consent of the Local Board.

4. **Strategic and Business Plan**. It shall be Buyer's goal to continue to enhance and develop the existing clinical services of the Business for the benefit of the Community, and to create a successful, sustainable health care delivery system in that Community. After the

Effective Date of this LOI and before Closing of the Definitive Agreements, the Parties will collaboratively develop an initial 5-year strategic and business plan to identify Community needs for institutional, physician and ambulatory care services, and identify the resources necessary to meet such needs (the "*Plan*"). The Plan will include (i) opportunities to expand the Business's service lines within the Community, (ii) supporting recruitment and retention of primary care and specialty care physicians in the Community, and employing or contracting with such physicians by an entity aligned or affiliated with the Hospital, (iii) developing a tertiary affiliation and becoming part of a network or system of health care providers that spans the care continuum, and includes preventive care, ambulatory care, urgent care, acute care, chronic care, post-acute care, behavioral health care, rehabilitation, and home care services accessible to the Community, and (iv) developing or obtaining the information technology, medical home and medical management infrastructure to provide patient-centric, population health management and assume financial risk for managing the quality and cost of health care services provided to defined populations in the Community. The Parties will also agree on the budget associated with the Plan, and the financial plan to implement the Plan. The Plan will specify the action steps, timelines and milestones to achieve the above goals, and certain commitments of Buyer contained in the Plan shall be included in the Definitive Agreements. After Closing, Buyer agrees to use commercially reasonable efforts to execute and implement the Plan in accordance with its terms, as the Plan may be modified by Buyer from time to time; provided that any material modification to the Plan shall be subject to approval by the Local Board, which approval will not be unreasonably withheld, conditioned, delayed or denied.

5. **Capital Commitments**. Buyer commits to invest, or cause third parties to invest, the necessary capital to meet the Hospital's capital needs when and as they arise, and to sustain Hospital as a comprehensive acute care community hospital. In addition to the Purchase Price, Buyer agrees to make, or cause to be made, at least a Fifty Million Dollar ($50,000,000) capital commitment to the Business, to be expended within five (5) years after the Closing in consultation with the Local Board.

6. **Ongoing Commitments**. For a period of at least ten (10) years following Closing, Buyer agrees to maintain all existing "core clinical services" of Seller (as defined by mutual agreement in the Definitive Agreements) at not less than current levels, except for those services that the Parties mutually agree in the Definitive Agreements or that the Local Board agrees may be changed during such period. In addition, after the Closing, the New Hospital will maintain or enhance Seller's historic commitment to quality, safety and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under the Medicare and Medicaid programs.

(a) Buyer shall strive to ensure, at all times after Closing, that the Hospital meets identified targets and goals with respect to regulatory, quality and safety measures and patient experience measures (e.g. OHCA and DPH reporting, Core Measures, Outcome Measures and HCAHPS), all as amended from time to time.

(b) Buyer also acknowledges that Seller has historically provided significant levels of care for indigent and low-income patients and has also provided care through a variety of Community-based health programs. Buyer will, at all times after Closing, cause the Hospital to adopt, maintain, and adhere to Seller's current policies on charity, indigent care and community

benefit, or adopt other policies and procedures that are at least as favorable to the indigent, uninsured and the Community in the aggregate as Seller's existing policies and procedures (which policies and procedures shall be subject to the approval of the Connecticut Attorney General to the extent required by law or to obtain regulatory approvals of the transactions contemplated by this LOI). Buyer will also strive to provide care through Community-based health programs, including cooperation with local organizations that sponsor healthcare initiatives to address identified Community needs and improve the health status of the elderly, poor, and other at-risk populations in the Community.

7. **Medical Staff Matters**. The Parties will involve physicians on the Medical Staff of Bristol Hospital ("*Medical Staff*") in developing the Plan, to ensure that the critical needs of the Medical Staff are met, and that strategic initiatives and investments are prioritized to best meet the needs of Medical Staff physicians and their patients.

(a) Pursuant to Section 1(c), Buyer agrees to assume at Closing all existing Seller contracts for hospital-based medical groups and physicians. For a period of five (5) years after Closing, Buyer agrees to consult with the Local Board before (i) replacing a hospital-based medical group or physician, unless Buyer is doing so in connection with a for cause termination of such medical group's or physician's contract with Seller or its affiliate, or (ii) placing any Vanguard-employed physician at any location within the Hospital's primary or secondary service area. For purposes of this Section "Vanguard-employed physicians" does not include any physician currently employed by Bristol Hospital Multi-Specialty Group ("*BHMSG*") or who is employed after the Closing by the successor entity to BHMSG. The Hospital's primary and secondary service area will be defined in the Definitive Agreements.

(b) Buyer will encourage and support participation by both independent and employed physicians who are members of the Medical Staff in Vanguard's Physician Leadership Council.

(c) The Parties will involve BHMSG physicians in the process of determining the corporate and organizational structure of the successor entity to BHMSG, and the manner in which employed and non-employed members of the Medical Staff may contract with such entity for employment or services. The Parties will also involve BHMSG and other Medical Staff physicians in determining the entity that will have payer contracting authority for employed and non-employed physicians. These matters will be subject to mutual agreement of the Parties in the Definitive Agreements.

8. **Employee/Benefit Matters**. Buyer will extend offers of employment at comparable base salaries and wages, with no pay reduction for at least 12 months after the Closing, to all of Seller's employees who are actively employed and in good standing at the Closing, excluding those employees that have written employment agreements assumed by Buyer as the terms of their employment shall be governed by such employment agreements. Buyer will give seniority credit to all of Seller's employees based on their period of employment by Seller, and Seller's employees will retain their current seniority and vesting in Seller's benefit plans and/or in any successor benefit programs of Buyer. Buyer will assume and honor all existing severance agreements between Seller and Seller's employees. Seller has provided a copy of all severance agreements to Buyer as of the Effective Date. As of the Closing, Buyer will provide Seller's

employees with a retirement plan, vacation, sick leave, holidays, health insurance, life insurance, and other employee benefits consistent with benefits offered to employees of similarly situated Vanguard entities. Buyer will also honor and assume all accrued paid time off accounts of Seller's employees as they exist at the Closing. In addition, Buyer will assume and honor all existing collective bargaining agreements that pertain to the Business. Seller has provided a copy of all collective bargaining agreements that pertain to the Business to Buyer as of the Effective Date. Further, Buyer agrees to assume and administer Seller's frozen defined benefit pension plan.

9. **Access to Information; Due Diligence**. Following the execution of this LOI and pending the execution of the Definitive Agreements, each party will permit the other party and its representatives to have reasonable access during normal business hours to such reasonable books, agreements, papers, and records relating to the business of the other party, including with respect to the Hospital, as is necessary to conduct appropriate due diligence activities relating to the Transactions. Such access will be conducted in a manner that will not interfere with the operations of the other party's business. Each party shall make available to other all requested due diligence information and documents pertaining to the business of the other within twenty (20) days of the Effective Date. All due diligence shall be complete before Definitive Agreements are executed, and continuing satisfactory due diligence results will not be a condition to Closing.

10. **Limitation on Sales**. For a period of five (5) years after Closing, subject to mutually agreed exceptions for exigent regulatory requirements and to market demands (as determined by the Local Board), Buyer will not sell or transfer all or substantially all of the stock, or all or substantial Purchased Assets or assets of the Business, nor may Buyer merge, consolidate, spin-off, close, liquidate, or dissolve the Business (each a "*Transfer*"), without the prior consent of the Local Board, which consent will not be unreasonably withheld, conditioned, delayed or denied. Thereafter, for the next five (5) years, the Hospital CEO and Local Board will be consulted in a timely manner prior to any such proposed Transfer, other than a Transfer to an affiliate of Buyer. For a period of ten (10) years after Closing, Seller, or a designee of Seller who does not compete with Buyer, will have a reasonable right of first opportunity to purchase for fair market value, all or substantially all of the stock of, and all or substantial Purchased Assets or assets of the Business (as it be upgraded, expanded or changed) that Buyer may decide to Transfer. For purposes of this Section "substantial assets" means twenty-five percent (25%) or more of all of the assets of the Business. Notwithstanding the foregoing, Buyer and all NewCos may pledge all assets of the Business, and any subsidiary of Vanguard that owns an equity interest in a NewCo may pledge such equity interest, pursuant to Vanguard's principal credit agreement and the lenders under the principal credit agreement (or any agent acting on their behalf) may foreclose upon such assets and equity interest.

11. **Representations, Warranties and Indemnities**. The Definitive Agreements will contain standard representations, warranties and indemnities for a transaction of this nature, including indemnification of Buyer against pre-Closing liabilities of Seller (other than Assumed Liabilities). Any indemnity claims with respect to breaches of representations and warranties shall be subject to (a) a "basket" equal to $500,000 (the "*Deductible Amount*"), at which point the indemnified parties will be indemnified against all the claims/liabilities to the extent they

exceed the Deductible Amount, and (b) a ceiling of $10 million in the aggregate. The Parties shall agree in the Definitive Agreements to an indemnity reserve for a period of three (3) years so that Buyer will have meaningful financial recourse against Seller for indemnification claims; provided that if one or more indemnification claim is brought by Buyer within the three (3) year indemnification reserve period, then the indemnification reserve will be extended for a period of one (1) year from the date of the last claim brought within that initial three (3) year reserve period. The Community Foundation shall not be an indemnitor, and the Community Foundation shall not be a guarantor of any Seller liability to Buyer. The representations and warranties contained in the Definitive Agreements shall survive for a period of two (2) years, except only for claims of fraud, claims related to title to the Purchased Assets and environmental claims, which shall survive for the applicable statute of limitations.

12. **Break-Up Fee**. In the Definitive Agreements, there will be a mutually agreeable break-up fee of $2.5 million that will be payable by the breaching Party if a Party refuses to close the transaction in breach of the Definitive Agreements.

13. **Closing/Conditions**. The Closing of the Transactions shall occur on the later of (i) 90 days from the execution of the Definitive Agreements, (ii) the date all regulatory approvals for the Transactions are obtained, or (iii) such other date as the Parties may mutually agree (the "*Closing*"). The Closing shall occur at 10 a.m. on the Closing date at the offices of Foley & Lardner LLP, 111 Huntington Avenue, Boston, MA 02199, or at such other time and place as the Parties may mutually agree. The Closing is conditioned, among other things, on:

(a) Mutual agreement on the terms and conditions of Definitive Agreements that incorporate and are consistent with the terms of this LOI, and include such other provisions as the Parties may mutually agree (the "*Definitive Agreements*"). The Parties will use good faith efforts to negotiate and enter into Definitive Agreements within 60 days after the Effective Date of this LOI.

(b) All necessary regulatory approvals, including certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, approval for conversion of the Hospital to for-profit status by the Attorney General of the State of Connecticut; and, if applicable, the waiting period under the Hart-Scott-Rodino amendments to the Antitrust Improvement Act shall have expired without any challenge by the Federal Trade Commission ("*FTC*") or the Department of Justice ("*DOJ*") to the implementation of the Transactions. Each Party shall have separate counsel for regulatory approval purposes, but will work cooperatively to obtain clearance and regulatory approvals for the Transactions. All regulatory filing fees will be borne solely by Buyer.

(c) Each of the Parties shall have obtained all third party approvals and consents that may be required under Seller's material contracts, agreements, leases and licenses that are assumed by Buyer in connection with the Transactions (the "*Consents*"), and any conditions imposed in connection with such Consents shall be reasonably acceptable to Buyer, or such third party Consents shall have been waived in writing by Buyer.

(d) The parties shall have developed the Plan, in accordance with Section 4.

(e) The implementation of the Transactions shall not be the subject of any injunction, litigation or regulatory investigation or adverse enforcement action.

(f) Each Party shall have obtained all such other consents and approvals as may be required by applicable law.

(g) The absence of a material adverse change affecting Seller, the Business or the Purchased Assets.

(h) The receipt by Buyer of acceptable environmental, engineering and title insurance reports and policies and ALTA land title surveys.

(i) Seller shall have defeased its CHEFA bonds.

(j) The receipt by Buyer of an opinion of counsel to Seller satisfactory to Buyer.

(k) The satisfaction of other conditions customary in transactions of a similar nature and acceptable to the Parties.

The Closing shall not be conditioned on the acquisition of any other hospitals by Buyer or any of its affiliates or the establishment of any tertiary relationship.

14. **Usual Course Conduct of Business**. During the term of this LOI, Seller shall continue to operate in its usual, regular and ordinary manner consistent with past practices and to comply in all material respects with applicable laws, rules and regulations. Without limiting the generality of the foregoing, except for expenditures of which Buyer is aware that are in currently in Seller's approved capital plan, Seller agrees that, from the Effective Date of this LOI until the earlier of the: (i) effective date of the Definitive Agreements or (ii) date this LOI terminates (other than as a result of entering into the Definitive Agreements), Seller shall not, without the prior written consent of Buyer: (a) amend its articles of organization or its bylaws, (b) enter into any indebtedness, contract, obligation or other undertaking that has required payments by Seller in excess of $250,000 unless such contract, obligation or undertaking can be terminated without financial penalty upon no more than 90 days written notice, (c) make any distributions of cash or other assets, except in the ordinary course of its business, (d) make capital expenditures in excess of $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual capital or operating budgets, (e) changes in title or duties of the Chief Executive Officer of Seller, (f) enter into any tertiary affiliation, other than the Yale Network Member Agreement that has been provided to Buyer, or (g) remove or transfer any of the Purchased Assets other than in the ordinary course of business (with adequate replacement of any Purchased Asset that is removed or transferred) .

15. **Exclusivity.** The Parties understand that negotiating and planning for the Transactions will require a significant commitment of time and effort. Accordingly, the Parties agree that, during the term of this LOI, and during the period between execution of Definitive Agreements and Closing (collectively, the "*Exclusivity Period*"), Seller will not, and will not permit any person acting for or on its behalf to, (a) offer for sale the Purchased Assets (or any material portion thereof) or any ownership interest in any entity owning any of the Purchased Assets, (b) solicit offers to buy all or any material portion of the Purchased Assets or any ownership interest

in any entity owning any of the Purchased Assets, (c) hold discussions with any person (other than Vanguard) looking toward such an offer or solicitation or looking toward a merger or consolidation of any entity owning any of the Purchased Assets or (d) enter into any agreement with any person (other than Vanguard) with respect to the sale or other disposition of the Purchased Assets (or any material portion thereof) or any ownership interest in any entity owning any of the Purchased Assets, or with respect to any merger, consolidation, or similar transaction involving any entity owning any of the Purchased Assets. If Seller breaches this Section 13, the Parties agree that irreparable harm may result for Buyer. Accordingly, Seller agrees that in the event of its breach or threatened breach of this Section 13, Buyer shall be entitled to injunctive relief, specific performance and other equitable relief, without proof of monetary damages or the need to post a bond or other surety.

16. **Confidentiality.** The Parties acknowledge that in order to pursue the Transactions certain confidential information will need to be shared. In order to facilitate sharing such information, the parties agree to abide by the Confidentiality Agreement between the Parties, dated January 9, 2012 (the "*Confidentiality Agreement*"), and the confidentiality obligations set forth in this Section 14.

(a) For the purposes of this LOI, "*Confidential Information*" means this LOI and any information or data disclosed in connection with this LOI in any form (verbal or written) or media whatsoever (including written, electronic, and verbal) by either Party (the "*Disclosing Party*") to the other party (the "*Receiving Party*"), including but not limited to any plans, processes, procedures, methods, financial information, patient information, documents, data, records, studies, reports, designs, specifications, ideas, concepts, contracts, software, or any compilation or combination of the foregoing, and all originals, copies, notes, correspondence conversations and other manifestations, derivations and analysis. Confidential Information shall not include information that: (i) is or becomes generally available to the public other than by reason of the Receiving Party's breach of this LOI; (ii) is or becomes known by the Receiving Party, prior to its disclosure by the Disclosing Party, without any obligation to hold it in confidence; (iii) is received from a third party free to disclose such information without restriction; (iv) is independently developed by the Receiving Party without the use of Confidential Information of the Disclosing Party; or (v) is approved for release by written authorization of the Disclosing Party, but only to the extent of such authorization.

(b) Notwithstanding anything to the contrary set forth in this LOI, the Receiving Party shall not be obligated to keep confidential any Confidential Information that: (i) is required by law or regulation to be disclosed, but only to the extent and for the purposes of such required disclosure; or (ii) is disclosed in response to a valid order or request of a court or other governmental authority having jurisdiction or in pursuance of any procedures for discovery or information gathering in any proceeding before any such court or governmental authority, but only to the extent of and for the purposes of such order, provided that the Receiving Party who is subject to such order or discovery gives the Disclosing Party reasonable advance notice, if permitted by law or the applicable governmental authority, so as to afford the Disclosing Party an opportunity to appear, object and obtain a protective order or other appropriate relief regarding such disclosure. The Receiving Party subject to such order or discovery shall, at the Disclosing Party's expense, use reasonable efforts to assist the Disclosing Party's efforts to obtain a protective order or other appropriate relief.

(c) The Receiving Party shall, subject to the other provisions of this LOI, use Confidential Information only for purposes of evaluating or facilitating the Transactions between the Parties, including disclosing Confidential Information as necessary to obtain any necessary governmental approvals or third party consents. The Receiving Party shall restrict disclosure of Confidential Information to employees and advisors of the Receiving Party and affiliates with a "need to know" and not disclose it to any other person or entity without prior written consent of the Disclosing Party. A "need to know" means that the employee or advisor requires the Confidential Information to perform his or her responsibilities in evaluating or pursuing the Transactions. When Confidential Information is disclosed by a Receiving Party within its organization, the employees or advisors who access the Confidential Information will be informed of their obligations to maintain the confidentiality of the Confidential Information. Further, Confidential Information will only be copied by the Receiving Party as necessary to inform those with a "need to know", and all copies will include confidentiality notices, if so contained on the originals disclosed by the Disclosing Party.

(d) The Receiving Party shall use not less than the degree of care used to prevent disclosure of its own proprietary and confidential information to prevent disclosure of Disclosing Party's Confidential Information. In no event, however, shall less than a reasonable degree of care be used. The Receiving Party shall take all actions reasonably necessary to assure that its employees, contractors, agents, affiliated entities, and all of their employees, contractors, and agents comply with the terms of this LOI, and the Receiving Party shall be responsible for any breach of this Section 14 by its employees, contractors, agents, affiliated entities, and all of their employees, contractors, and agents.

(e) Confidential Information shall be deemed to be the property of the Disclosing Party. This LOI shall not be interpreted or construed as granting any license or other right under or with respect to any trade secret or other proprietary right of a Disclosing Party. The Definitive Agreements shall provide that any Confidential Information of Seller that constitutes a Purchased Asset shall be the property of Buyer or a NewCo, and from and after the Closing Buyer or NewCo shall use or disclose such Confidential Information as it deems appropriate.

(f) Each Party acknowledges that the Confidential Information received from the other Party hereunder constitutes valuable confidential, commercial, business and proprietary information of the Disclosing Party and that serious economic disadvantage or irreparable harm may result for the Disclosing Party if the Receiving Party breaches its nondisclosure obligations under this LOI. Accordingly, the Parties agree that in the event of threat of disclosure of any Confidential Information, or breach of this Section 14 by the Receiving Party, the Disclosing Party shall be entitled to injunctive relief, specific performance and other equitable relief, without proof of monetary damages or the need to post a bond or other surety.

(g) Upon termination of this LOI, a Receiving Party will return or destroy any Confidential Information that it has received from a Disclosing Party, unless the Disclosing Party expressly waives this requirement with respect to specifically enumerated documents.

17. **Termination.** This LOI shall terminate if the Parties have not executed Definitive Agreements within sixty (60) days of the Effective Date of this LOI, or such later date as the Parties may mutually agree. In addition, either Party may terminate this LOI upon ten (10) days

prior written notice to the other Party if the other Party materially breaches this LOI, and such breach is not cured during the ten (10) day notice period. Upon termination of this LOI, the non-solicitation provisions of the Confidentiality Agreement shall be and remain in effect.

18. **Publicity.** The Parties will not make any public announcement and will keep strictly confidential the existence of this LOI, and their negotiations of any potential Transaction, and will not issue any press release or other public statement relating thereto, without the express consent of the other Party. Notwithstanding the foregoing in this Section 17, disclosures required by applicable law are permitted by the Parties, in which case the Parties will consult and cooperate with each other to the extent reasonably practical in advance of any such disclosure.

19. **Expenses**. Each Party shall bear its own respective costs associated with the Transactions, including the cost of its respective attorneys, accountants, brokers and other advisors. Buyer shall pay all other Closing costs, including the cost of title insurance, land surveys, documentary stamps, transfer taxes, recording fees and similar Closing costs. Buyer shall also be responsible for the costs of conducting its due diligence review of the Business and Purchased Assets.

20. **Binding Commitment.** None of the terms of this LOI shall be binding or create any legal obligation of either Party to enter into the Transactions, except for the second sentence of Section 13(a) and Sections 14-23 of this LOI, which shall be binding on the Parties. If the Parties decide to proceed with the Transactions, then all of the agreements, representations, warranties, covenants and conditions with respect thereto shall be only as set forth in the Definitive Agreements. The Parties further expressly acknowledge that prior to the execution of this LOI there have not been any binding commitments, agreements or understandings between them with respect to the Transactions or any future relationship of any kind, other than as specified in the Confidentiality Agreement.

21. **Governing Law.** This LOI shall be governed by the substantive laws of the State of Connecticut without regard to the conflicts of law principles thereof. The Parties consent to the jurisdiction of the courts of the State of Connecticut and of any federal court located in the State of Connecticut in connection with any action or proceeding arising out of this LOI. The Parties waive any objection they may have to the laying of venue in the state or federal courts located in Hartford, Connecticut of any action or proceeding arising out of this LOI. In any action to enforce this LOI or on account of any breach of this LOI, the prevailing party shall be entitled to recover, in addition to all other relief, its reasonable attorneys' fees, court costs and consultancy fees associated with such action. No Party shall be liable to another Party for any consequential, indirect, incidental, special, exemplary or punitive damages arising out of or related to this LOI.

22. **Entirety.** This LOI constitutes the entire understanding and agreement between the Parties and their affiliates with respect to its subject matter and supersedes all prior or contemporaneous agreements, representations, warranties and understandings of the Parties, whether oral or written, other than the Confidentiality Agreement. Parol evidence and extrinsic evidence shall be inadmissible to show agreement by and between the Parties to any term or condition contrary or in addition to the terms and conditions contained in this LOI.

23. **Miscellaneous.** No Party may transfer or assign all or any of its rights, obligations or benefits hereunder in whole or in part to any third party, without the prior written consent of the other Party. This LOI may be amended only by written agreement, signed by a duly authorized officer of each Party. This LOI may be executed in counterparts (and the same may be delivered by means of facsimile or pdf file), each of which shall be deemed an original and to constitute one and the same instrument.

* * *

[*remainder of page intentionally left blank*]

Please confirm your agreement with the foregoing by having this LOI signed where indicated below and returning a signed copy of this LOI to me.

Sincerely,

Kurt Barwis, CEO
Bristol Hospital & Health Care Group, Inc.,
On behalf of itself and its Affiliates

ACCEPTED AND AGREED:
Vanguard Health Systems, Inc.

By: _____
Keith Pitts, Vice Chairman

Please confirm your agreement with the foregoing by having this LOI signed where indicated below and returning a signed copy of this LOI to me.

Sincerely,

Kurt Barwis, CEO
Bristol Hospital & Health Care Group, Inc.,
On behalf of itself and its Affiliates

ACCEPTED AND AGREED:
Vanguard Health Systems, Inc.

By: _____
Keith Pitts, Vice Chairman

From: "MBlau@foley.com" <MBlau@foley.com>
To: "'Faldetta, John'" <jfaldetta@vanguardhealth.com>,
Cc: "'sjarvaweiss@nmmlaw.com'" <sjarvaweiss@nmmlaw.com>, "'Barwis, Kurt'" <KBarwis@bristolhospital.org>, "'James E. Cain'" <jcain@cainbrothers.com>, 'Jason Horowitz' <jhorowitz@cainbrothers.com>, "'Jay, Rob'" <rjay@vanguardhealth.com>, "'Messina, Travis'" <tmessina@vanguardhealth.com>
Date: 02/08/2013 03:11 PM
Subject: RE: Bristol LOI

Thank you, John. Please accept this email as confirmation of the extension of the LOI until March 15th on the terms referenced below.

Michael L. Blau
Foley & Lardner LLP
111 Huntington Avenue
Boston, MA 02199
617.342.4040
Fax 617.342.4001
mblau@foley.com

From: Faldetta, John [mailto:jfaldetta@vanguardhealth.com]
Sent: Friday, February 08, 2013 11:08 AM
To: Blau, Michael L.
Cc: 'sjarvaweiss@nmmlaw.com'; 'Barwis, Kurt'; 'James E. Cain'; 'Jason Horowitz'; Jay, Rob; Messina, Travis
Subject: RE: Bristol LOI

Michael,
We are agreeable to the extension of the LOI until March 15th. I have no comments on your proposed language below for the extension.
Thanks,
John

John J. Faldetta, Jr.
Vice President & Assistant General Counsel

615.665.6133 | Direct
615.428.3929 | Mobile
615.665.6197 | Fax
vanguardhealth.com

From: MBlau@foley.com [mailto:MBlau@foley.com]
Sent: Wednesday, February 06, 2013 5:18 PM
To: Faldetta, John
Cc: 'sjarvaweiss@nmmlaw.com'; 'Barwis, Kurt'; 'James E. Cain'; 'Jason Horowitz'

Subject: RE: Bristol LOI

John,

Thank you for your response. I checked with my client, and we would prefer to extend the LOI through March 15th, rather than March 31st, if that is OK with you. The following is the language for the proposed extension:

Reference is made to that certain Letter of Intent (this "*LOI*") dated November 26, 2012 (the "*Effective Date*") by and among **Bristol Hospital & Health Care Group, Inc.,** on behalf of itself and its affiliates ("*BHHCG*"), and **Vanguard Health Systems, Inc.** ("*Vanguard*" and, together with BHHCG, the "*Parties*"). Under Section 17 of the LOI, this LOI terminates if the Parties have not executed Definitive Agreements within sixty (60) days of the Effective Date, or such later date as the Parties may mutually agree. This is to confirm that the Parties have mutually agreed to extend the date for completion of Definitive Agreements until March 15, 2013, or such other date as the Parties may mutually agree.

Please let me know if Vanguard agrees with the extension on these terms.

Thank you, and best regards,

Michael L. Blau
Foley & Lardner LLP
111 Huntington Avenue
Boston, MA 02199
617.342.4040
Fax 617.342.4001
mblau@foley.com

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 6: YALE NETWORK MEMBER AGREEMENT

NETWORK MEMBER AGREEMENT

This Network Member AGREEMENT (the "Agreement") is entered into as of the ___th day of October, 2012, by and between BRISTOL HOSPITAL, a Connecticut nonstock corporation ("Network Member") and YALE-NEW HAVEN HEALTH SERVICES CORPORATION, a Connecticut nonstock corporation ("YNHHS"). Network Member and YNHHS are collectively referred to herein as the "parties" and individually as a "party."

WHEREAS, YNHHS maintains an integrated delivery network of health care providers (the "Network") that offers an extensive range of world class health care services, including inpatient, outpatient, ambulatory, rehabilitative, long-term and home care services, through general and acute care hospitals, ambulatory surgery centers, clinics and other health care facilities;

WHEREAS, Network Member owns and operates a general hospital facility in Bristol, Connecticut that provides a full range of high quality, cost effective health care services;

WHEREAS, Network Member and YNHHS share a common desire for the integrated delivery of health care services in a manner that enhances and promotes high quality patient care through documented improved outcomes and community health status;

WHEREAS, Network Member and YNHHS believe that participation by Network Member in the Network will enhance the coordination of health care services in the communities served by the parties, improve access to quality health care services in those communities, ensure the continued availability of high quality health care services in those communities, and provide other clinical, educational and charitable benefits to patients of the Network and the communities served by the parties.; and

WHEREAS, Network Member and YNHHS desire to affiliate to provide on a collaborative basis certain mutually agreed health care services of excellence in an effort to coordinate care and meet the evolving health care needs of patients in the region.

NOW, THEREFORE, in consideration of the premises and the terms, covenants and conditions hereinafter set forth, the parties mutually agree as follows:

1. **Definitions**.

"Affiliate" means, with respect to any Entity, any other Entity which at the time Affiliate status is being determined is (i) directly or indirectly Controlling or Controlled by, or (ii) under direct or indirect common Control with such Entity. For the purposes of determining Affiliate status, "Control" shall mean the legal power to (a) elect or cause the election of all or a substantial part of the governing body of the subject Entity, or (b) direct, cause the direction of, or exert substantial influence over the subject Entity's day-to-day operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means. For the purposes of this Agreement, references to Network Member shall be deemed to refer to Network Member and its Affiliates and references to YNHHS shall be deemed to refer to YNHHS and its Affiliates.

"Entity" means a corporation, association, partnership, trust, limited liability company, organization, business or any other entity.

"Integrated Delivery System" means a healthcare service provider system that delivers hospital, physician or other services on a coordinated basis.

"Network Member" means Bristol Hospital, a Connecticut nonstock corporation. By execution of this Agreement, the Network Member shall be a member in the Network in accordance only with the terms and conditions set forth in this Agreement. The Network Member acknowledges and agrees that neither the Network Member's membership in the Network nor any provision in this Agreement shall be construed to mean that the Network Member is a member of YNHHS for purposes of Title 33, Chapter 602, Sections 33-1000 to 33-1290 of the General Statutes of Connecticut (the "Connecticut Revised Nonstock Corporation Act") and as a result, the rights and privileges of members conferred under the provisions of the Connecticut Revised Nonstock Corporation Act shall not be deemed to be applicable to the Network Member.

"Network Service" means a service provided by YNHHS as set forth on Appendix A. Appendix A shall be revised by the parties from time to time by mutual agreement of the parties to include additional Network Services to be provided by YNHHS. In addition, YNHHS may add, delete or otherwise modify existing Network Services from time to time in accordance with the terms of this Agreement..

"Restructuring Transaction" means any material change in Network Member's affiliations or corporate structure or those of any Affiliate of Network Member, including without limitation: (i) any transfer of substantial assets, any merger or change of control of Network Member or an Affiliate; (ii) any material change in persons with the right to nominate, elect or approve directors of Network Member or an Affiliate; (iii) any change in identity of Network Member's or Affiliate's members, other than a change (in the normal course) in the individuals who may be members, or (iv) any arrangement by which substantial influence over the management or operations of Network Member or an Affiliate of Network Member is exerted by a third party.

"Other Affiliation Transaction" means any agreement between Network Member or any Affiliate of Network Member with any other organization or entity, or group of entities, that directly or indirectly owns, controls or operates a hospital or health system (or any Affiliate of a hospital or health system) regarding any material clinical, programmatic or operational commitment.

"Service Agreement" means a written agreement memorializing the specific terms and conditions on which a Network Service is provided to Network Member, one (1) or more of its Affiliates, or a related Entity.

For purposes of this Agreement, capitalized terms defined elsewhere in this Agreement have the meanings so ascribed to them.

2. **Network Member**. As a member of the Network, the Network Member may obtain certain Network Services as described herein for itself and for its Affiliates. Network Member

will cause its Affiliates to abide by the covenants and agreements set forth in this Agreement, including without limitation participating in applicable Network Services, and will deliver to YNHHS an Agreement to be Bound in the form attached hereto as Appendix B for each Affiliate desiring to participate in any such Network Service.

3. **Elements of Participation**.

3.1 YNHHS and the Network Member agree to meet on a regular basis in order to identify and prioritize potential Affiliation activities, including, but not limited to, the development of joint clinical programs or operations with YNHHS and/or its Affiliates (the "Affiliation Activities"). The initial priority Affiliation Activities will include negotiating and mutually agreeing on (i) transfer protocols by which Yale New Haven Hospital (the "Hospital") will receive transfers from Network Member for tertiary and quaternary care, (ii) protocols by which the Hospital and its Medical Staff physicians will respond to and communicate with Network Member and its Medical Staff physicians regarding patients who are transferred to the Hospital for such care, and (iii) protocols for discharging patients so transferred back to their community under the care of Medical Staff physicians of Network Member. Each Affiliation Activity that is approved by both YNHHS (or its Affiliates) and Network Member is herein referred to as an "Approved Affiliation". Until an Affiliation Activity is approved as an Approved Affiliation, the parties may terminate exploration of any such Affiliation Activity that is under discussion at any time by either. The parties will negotiate in good faith the terms and conditions of each Approved Affiliation. The terms and conditions of any Approved Affiliations will be reduced to writing and attached hereto as Appendix C. The rights and obligations of YNHHS and Network Member relating to each Approved Affiliation will be established by the definitive Service Agreement(s) executed pursuant to the terms of Section 3.3 below.

3.2 Each of YNHHS and Network Member desire that Network Member participate in the Network through participation in certain Network Services, including certain group purchasing services. Subject to Section 5.4, Network Services are offered to Network Member by YNHHS with the understanding that Network Member will obtain them from YNHHS should Network Member desire such Network Services for Network Member's operations. Network Member will negotiate in good faith a Services Agreement pursuant to which YNHHS will provide such specific Network Services to Network Member. From time to time YNHHS may add, discontinue or modify Network Services by providing at least sixty (60) days prior written notice to Network Member. If Network Member objects to any such change in Network Services, Network Member may terminate either the Network Service(s) affected by the change or this Agreement, by notice to YNHHS at any time within the original sixty (60) day notice period.

3.3 The rights and obligations of YNHHS and Network Member relating to each Network Service, including the group purchasing services referred to in Section 3.2, and any Approved Affiliation will be established by a definitive Service Agreement specifying the terms and conditions of that Network Service or Approved Affiliation. Any such definitive Service Agreement will be attached hereto as part of Appendix C. In the event of a conflict between the provisions hereof and the provisions of applicable Service Agreements, the terms of any executed Service Agreement will control as to the subject matter of the applicable Network Service or Approved Affiliation.

4. **Services**. The Network Services offered to Network Member are set forth on Appendix A hereto and may be changed from time to time by YNHHS. As of date hereof, the Network Services are listed in Appendix A. Except as otherwise provided herein, the fees paid by Network Member to YNHHS for Network Services shall be defined in the applicable Service Agreement. Subject to Section 5.4, before obtaining Network Services (or services comparable to Network Services) from third parties, Network Member will negotiate in good faith to enter into a Service Agreement with YNHHS to obtain such Network Services. YNHHS shall offer to Network Member as Network Services any service offered by YNHHS to any other member of the Network on financial terms equal to the most favorable terms applicable to any other acute care community hospital member of the Network.

5. **Network Commitment**.

5.1 Network Member will have the opportunity to participate in educational meetings that YNHHS conducts relating to the Network. Network Member agrees to attempt in good faith to participate actively in such meetings and other collaborative activities relating to the Network that YNHHS makes available to Network members.

5.2 YNHHS Right of First Opportunity. In furtherance of achieving the goals of this Agreement, Network Member agrees that during the term of this Agreement, (i) neither Network Member nor any Affiliate will enter into any Other Affiliation Transaction or any discussions relating thereto, without first offering YNHHS a reasonable right of first opportunity to develop a substantially similar program or service with Network Member or its Affiliate pursuant to this Agreement; and (ii) once Network Member and YNHHS have agreed to develop and implement a specific additional Approved Affiliation hereunder, neither Network Member nor its Affiliates will enter into any agreement, or any discussions relating thereto, with any other hospital or health system (or any Affiliate of such a hospital or health system) regarding the development or operation of a substantially similar program or service.

5.3 For the purposes of Section 5.2 hereto, "reasonable right of first opportunity" shall mean that the party that proposes or is presented with the opportunity (the "Recipient") shall promptly give the other party (the "ROFO Party") written notice of the opportunity as soon as it is proposed to the Recipient by, or before the Recipient proposes such opportunity to, an applicable third party hospital or health system (or Affiliate thereof). The ROFO Party will thereafter have a period of sixty (60) days within which to exercise its right of first opportunity. If the ROFO Party declines the opportunity or fails to exercise its right of first opportunity in a timely manner, then the Recipient shall be free to develop and implement the program or service with any other hospital or health system (or Affiliate thereof). If the ROFO Party exercises its right of first opportunity in a timely manner, it shall do so by delivering to the Recipient within that sixty (60)-day period an initial written proposal for jointly pursuing the opportunity. If the ROFO Party delivers such a proposal to the Recipient in a timely manner, then for a period of at least sixty (60) days from the Recipient's receipt of that proposal, the parties agree to negotiate mutually agreed terms and conditions under which the opportunity would become an Approved Affiliation hereunder. During that one hundred twenty (120)-day period, the Recipient will negotiate exclusively with the ROFO Party regarding the opportunity, and the parties agree to negotiate any such potential Affiliation in good faith.

5.4 Notwithstanding anything in this Agreement to the contrary, YNHHS acknowledges and agrees that Network Member and its Affiliates are free, during the term of this Agreement, to enter into a Restructuring Transaction and Other Affiliation Transactions (including for Network Services and Service Agreements) with (i) LHP Hospital Group, Inc.; (ii) Vanguard Health Systems, Inc.; or (iii) any third party that, in the judgment of the governing board of Network Member, will meet Network Member's current capital needs and that does not directly or indirectly own, control or operate an academic tertiary hospital or health system (or any Affiliate of such an academic tertiary hospital or health system) (each a "Capital Partner"); provided that if the Restructuring Transaction and/or Other Affiliation Transaction results in Network Member or an Affiliate directly or indirectly continuing to own a transferable or assignable interest in Bristol Hospital (or its successor), Network Member will use its best efforts to negotiate with its Capital Partner for a right to grant YNHHS or its designated Affiliate an option to acquire that interest from Network Member or its Affiliate at fair market value (based on the value determined by the Capital Partner in connection with the Restructuring Transaction) within a defined time period ("Yale Option"), not to exceed two (2) years from the closing date of the Restructuring Transaction ("Option Period"). In the event of such a Restructuring Transaction with a Capital Partner, this Agreement shall be assignable by Network Member to the successor in interest of Bristol Hospital.

5.5 Additional Terms. In addition, if YNHHS or any of its Affiliates, during the term of this Agreement and without prior approval with Network Member, (i) places any physician employed by YNHHS or any of its Affiliates in Bristol, CT, or (ii) acquires any medical group or physician practice whose principal place of business is located in Bristol, CT (any act in subsection (i) or (ii) is hereinafter referred to as a Physician Transaction"), then Network Member may terminate this Agreement on ninety (90) days prior written notice.

6. **Publicity**.

Network Member consents to use of Network Member's name in connection with any description of YNHHS 's network and Approved Affiliations. Otherwise, except as approved in advance and in writing by the other party, neither party shall use the other party's name, trademark, service mark or other identifying information in materials and marketing literature in any format, including, but not limited to, electronic media. With respect to YNHHS, this restriction shall apply to any variant of its name, trademark, service mark or other identifying information, including but not limited to "Yale New Haven".

7. **Term and Termination**.

7.1 Term. This Agreement shall extend from the date hereof for a period of five (5) years (the "Initial Term") and shall be automatically renewed for successive five (5) year periods (each, an "Extension Term") thereafter unless terminated by mutual agreement or pursuant to this Section 7.

7.2 Termination With Cause. This Agreement may be terminated as follows:

a. Bankruptcy. Either party may terminate this Agreement immediately upon written notice in the event that the other party ceases operations, becomes insolvent or bankrupt, makes an assignment for the benefit of creditors, or is the subject of a

bankruptcy petition or petition for dissolution, liquidation, or for the winding-up of business affairs, or for the appointment of a trustee or receiver to take possession of its assets.

b. Material Breach. Upon written notice of a material breach of this Agreement, unless the breach is of such a nature as to warrant immediate termination, the breaching party shall have thirty (30) days to cure the breach to the satisfaction of the non-breaching party. If the breach is not cured within such time, the non-breaching party may terminate this Agreement upon written notice.

c. Immediate Termination. This Agreement will, at the election of either party, terminate immediately upon the occurrence of any of the following with respect to any hospital affiliated with Network Member or YNHHS, except as a result of a Restructuring Transaction contemplated by Section 5.4: (i) loss or suspension of a hospital license or Medicaid or Medicare certification; (ii) loss of adequate insurance coverage; or (iii) loss of any accreditation from The Joint Commission or any similar accrediting organization; or (iv) pursuant to either Section 8.4 or Section 8.8.

d. Termination Without Cause. Either party may terminate this Agreement during an Extension Term at any time without cause on one (1) years' prior written notice to the non-terminating party. In addition, Network Member may terminate this Agreement (i) without cause at any time at or after the end of the Option Period referred to in section 5.4 if YNHHS or its designated Affiliate does not timely exercise the Yale Option specified in that Section, (ii) at any time on or after the closing date of a Restructuring Transaction if Network Member's Capital Partner does not agree to continue this Agreement and/or provide a Yale Option, or (iii) on ninety (90) days prior written notice in accordance with Section 5.5.

7.3 Effect of and Obligations after Termination. Except as otherwise provided herein, upon termination of this Agreement the provisions of this Agreement shall have no further force or effect; provided, however, that each party shall remain liable for any obligations or liabilities arising from activities carried on by such party prior to the effective date of termination. Upon termination and during any period in which a termination notice has been given, YNHHS and Network Member shall cooperate in notifying affected institutions, patients and providers of such termination and effecting a reasonable and orderly transfer of each party's operations affected by this Agreement. Notwithstanding the foregoing, each Service Agreement executed in connection herewith shall terminate on its own terms unless otherwise agreed to by the parties.

8. **General Provisions**.

8.1 Other Contracts. Nothing contained in this Agreement shall prevent Network Member or its related providers from rendering health care services pursuant to other contractual arrangements entered into without breach hereof.

8.2 Service Fees. As compensation for the Network Services and participation in Approved Affiliations, Network Member agrees to pay YNHHS in accordance with the Service Agreements attached hereto as Appendix C.

8.3 Independent Contractor Relationship. None of the provisions of this Agreement is intended to create, or shall be deemed or construed to create any relationship between YNHHS and Network Member other than that of independent entities contracting solely for the purpose of effectuating the provisions of this Agreement. YNHHS shall not be responsible for nor have control over the means, method or manner of delivery of services by Network Member or its affiliated providers pursuant to this Agreement or the arrangements contemplated hereby. Except as specifically provided in any applicable Service Agreement, neither of the parties nor any of their respective agents or employees shall be construed to be the agent, partner (for partnership law purposes), co-venturer, employee, or representative of any other party.

8.4 Warranty and Representation. The parties covenant, warrant and represent that neither party nor any director, officer, employee, member or shareholder thereof has ever been convicted of any act or omission constituting a felony under the laws of the State of Connecticut or constitute Medicare or Medicaid fraud or any other offense or violation under Title XVIII of the Social Security Act, 349 Stat. 620 (1935), as amended, or under any state health care program, as defined in 42 U.S.C. 1320a-7(b).

8.5 Amendments. This Agreement may only be amended by a written document, signed by the parties or as otherwise set forth in this paragraph.

8.6 Confidentiality. In order to facilitate the sharing of necessary information in connection with this Agreement, the parties agree to the following confidentiality obligations:

a. For the purposes of this Agreement, "Confidential Information" means any information or data disclosed in connection with this Agreement in any form (verbal or written) or media whatsoever by either party (the "Disclosing Party") to the other party (the "Receiving Party"), including, but not limited to designs, specifications, ideas, concepts, contracts, plans, software, processes, procedures, methods, financial

information, patient information, or any compilation or combination of the foregoing, and all originals, copies, notes, correspondence conversations and other manifestations, derivations and analysis pertaining thereto. Confidential Information shall not include information that: (i) is or becomes generally available to the public other than by reason of the Receiving Party's breach of this Agreement; (ii) is or becomes known by the Receiving Party, prior to its disclosure by the Disclosing Party, without any obligation to hold it in confidence; (iii) is received from a third party free to disclose such information without restriction; (iv) is independently developed by the Receiving Party without the use of Confidential Information of the Disclosing Party; or (v) is approved for release by written authorization of the Disclosing Party, but only to the extent of such authorization.

b. Notwithstanding anything to the contrary set forth in this Agreement, the Receiving Party shall not be obligated to keep confidential any Confidential Information that: (i) is required by law or regulation to be disclosed, but only to the extent and for the purposes of such required disclosure; or (ii) is disclosed in response to a valid order or request of a court or other governmental authority having jurisdiction or in pursuance of any procedures for discovery or information gathering in any proceeding before any such court or governmental authority, but only to the extent of and for the purposes of such order, provided that the Receiving Party who is subject to such order or discovery gives the Disclosing Party reasonable advance notice, so as to afford the Disclosing Party an opportunity to appear, object and obtain a protective order or other appropriate relief regarding such disclosure. The Receiving Party subject to such order or discovery shall, at the Disclosing Party's expense, use reasonable efforts to assist the Disclosing Party's efforts to obtain a protective order or other appropriate relief.

c. The Receiving Party shall, subject to the other provisions of this Agreement, use Confidential Information only for purposes of evaluating potential Collaborative Activities, in furtherance of Approved Affiliations, or in order to negotiate and appropriately provide the Network Services. The Receiving Party shall restrict disclosure of Confidential Information to employees and advisors of the Receiving Party and affiliates with a "need to know" and not disclose it to any other person or entity without prior written consent of the Disclosing Party. A "need to know" means that the employee or advisor requires the Confidential Information to perform his or her responsibilities in evaluating or pursuing a relationship between the Parties. When Confidential Information is disclosed by a Receiving Party within its organization, the employees or advisors who access the Confidential Information will be informed of their obligations to maintain the confidentiality of the Confidential Information. Further, Confidential Information will only be copied by the Receiving Party as necessary to inform those with a "need to know", and all copies will include confidentiality notices, if so contained on the originals disclosed by the Disclosing Party.

d. The Receiving Party shall use not less than the degree of care used to prevent disclosure of its own proprietary and confidential information to prevent disclosure of Disclosing Party's Confidential Information. In no event, however, shall less than a reasonable degree of care be used. The Receiving Party shall take all actions reasonably necessary to assure that its employees, contractors, agents, affiliated entities,

and all of their employees, contractors, and agents comply with the terms of this Agreement.

e. Confidential Information shall be deemed to be the property of the Disclosing Party. This Agreement shall not be interpreted or construed as granting any license or other right under or with respect to any trade secret or other proprietary right.

f. Each Party acknowledges that the Confidential Information received from the other Party hereunder constitutes valuable confidential, commercial, business and proprietary information of the Disclosing Party and that serious economic disadvantage or irreparable harm may result for the Disclosing Party if the Receiving Party breaches its nondisclosure obligations under this Agreement. Accordingly, the Parties agree that in the event of threat of disclosure of any Confidential Information, the Disclosing Party shall be entitled to injunctive relief, specific performance and other equitable relief, without proof of monetary damages.

8.7 Non-Solicitation. During the term of this Agreement, and for a period of one (1) year after the date of termination or expiration of this Agreement, neither party shall, without the express written consent of the other party, directly solicit for employment or engagement, verbally or in writing, any management or executive-level employee or contractor of the other party or any of its Affiliates. It is acknowledged that it shall not constitute a solicitation that is prohibited under this Section 8.7 for a party to engage in general advertising and other customary means of publicizing employment opportunities. It is expressly understood that the hiring of a management or executive-level employee who is not directly solicited for employment by a party shall not constitute a violation of this Section 8.7.

8.8 Excluded Provider.

a. Each party hereby represents and warrants that such party, its Affiliates, and their respective members, agents and employees are not and at no time have been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Each party hereby agrees to immediately notify the other of any threatened, proposed or actual exclusion of such party, its Affiliates or their respective members, agents or employees from any federally funded health care program, including Medicare and Medicaid. In the event that a party, or any of its Affiliates or their respective members, agents or employees are excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that a party is in breach of the requirements contained in this Section 8.8, the other party shall have the right to immediately terminate this Agreement as of the effective date of such exclusion or breach.

b. Each party shall indemnify and hold harmless the other party against all actions, claims, demands and liabilities, and against all loss, damage, costs and expenses, including reasonable attorneys" fees, arising directly or indirectly, out of any violation of this Section 8.8 by such party, or due to the exclusion of such party, or any of its

members, employees or agents from a federally funded health care program, including Medicare or Medicaid.

8.9 Assignment. Except as provided in Section 5.4 above, this Agreement may not be assigned by any party without the prior written consent of the non-assigning party.

8.10 Governing Law. This Agreement shall be construed in accordance with the laws of the State of Connecticut without giving effect to its conflict of laws principles, and in accordance with federal law if applicable. Network Member hereby consents to the jurisdiction of the courts of the State of Connecticut and the United States District Court of Connecticut with respect to any suit, action or other proceeding arising under or in respect of this Agreement or with respect to the transactions contemplated hereby, and expressly waives any and all objections Network Member may have to venue in any such courts. Network Member shall not bring any suit, action or other proceeding under or in respect of this Agreement in any courts other than the above.

8.11 Severability. If any provision of this Agreement shall for any reason be held to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid or unenforceable provision were omitted.

8.12 Notices. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be sent, postage prepaid, by certified mail, return receipt requested, to YNHHS or Network Member at the address given below or to such later address as may be specified in writing. The notice shall be effective on the date of delivery indicated on the return receipt.

If to YNHHS:

Yale-New Haven Health Services Corporation
789 Howard Avenue, New Haven, CT 06519
Attn: Gayle Capozzalo, executive Vice President-Strategy and System Development

If to Network Member:

Bristol Hospital
41 Brewster Road
Bristol, CT 06011
Attn: Kurt Barwis, President and Chief Executive Officer

8.13 Waiver of Breach. The waiver of any breach of this Agreement by any party shall not constitute a continuing waiver or a waiver of any subsequent breach of either the same or any other provision of this Agreement.

8.14 Exhibits. All exhibits, schedules, appendices and documents referred to in or attached to this Agreement are integral parts of this Agreement if fully set forth herein and all statements appearing therein shall be deemed to be representations.

8.15 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which together shall comprise one and the same instrument. Any signature page counterpart executed and delivered by a party by means of facsimile transmission or electronic mail as a .PDF file shall be deemed for all purposes of this Agreement as an original counterpart.

8.16 Entire Agreement. This Agreement, including its attachments, appendices, exhibits, and schedules, all hereby made a part hereof, constitutes the entire agreement between the Parties with respect to the matters addressed herein and supersedes all prior oral and written understandings between the parties, except for Service Agreements, which shall govern the subject matter thereof.

8.17 No Third-Party Beneficiary Rights. This Agreement is not intended to create, nor shall it be deemed to create, any third party beneficiary rights in any person.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth above.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____
Its

Network Member:
BRISTOL HOSPITAL

By: _____
Its President & CEO

APPENDIX A

YNHHS Network Services Available to Network Member

Service	Access Method
Patient Care/Safety, Quality and Service	
Patient safety and quality indicator measurements	Service line specific
Sharing best practices	Service line specific
Improvement support	Service line specific
System Conferences	Service available
Clinical Program Access	
Service line networks Cardiovascular Oncology Pediatrics Transplantation Telestroke Neurosciences	Service available
Clinical program planning	Service line specific
Clinical trial access	Service line specific
Protocol access	Service line specific
Education opportunities	Service line specific
Clinical consultations	Service line specific
Specialty physician access	Service line specific
Human Resources	
Workers Compensation administration and network	Service available/under contract
Institute for Excellence	
Management training	Service available
Clinical training	Service available
Physician leadership development	Service available
Simulation Center	Service available
Performance Management	
Electronic balanced scorecard	Service line specific
Six Sigma; LEAN; CAP; workout education	Service available
System conferences	Service available
Economics of Scale	
Association and data fees	Service line specific
Emergency preparedness	Service available
Supply Chain Management	Service available/under contract
Outsourcing	Service available/under contract
Information Technology	
Physician connectivity	Service available

Physician Support	
Access to physician specialties	Service available
Information Systems: HEALTHvision	Service available
Physician recruitment/employment	Service available
Shared Learning	
System councils	Service line specific
System Leadership Forum	Limited
System conferences	Service available
Marketing	
Access to brand	Limited
Call Center	Service available

APPENDIX B

Form of Agreement to be Bound

In order to induce Yale-New Haven Health Services Corporation to enter into the Network Member Agreement with Bristol Hospital, a Connecticut nonstock corporation dated_____, 2012 (the "Agreement"), as well as for other valuable consideration, the receipt of which is hereby acknowledged, and in accordance with the Agreement, and as a condition precedent to rendering any services pursuant to the Agreement, the undersigned agrees to be bound by the terms of the Agreement.

Dated as of this_____day of_____, 20__.

_____

_____

By:_____

Its:_____

APPENDIX C

Affiliations and Service Agreements

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 7: CONFLICT OF INTEREST DISCLOSURES - BHHCG

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") (the "Transaction").

All Members and officers of the Board of Directors of BHHCG and certain affiliates, key employees, and experts and consultants retained by BHHCG must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) BHHCG and certain affiliates board members and officers; (ii) experts and consultants retained by BHHCG and its affiliates in connection with the Transaction; and (iii) senior executives at BHHCG and certain affiliates with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Mark Sciarretta

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:

Company Name: Foley & Lardner, LLP

Title: Partner

____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

____ Bristol Hospital, Inc.

Position(s): _____

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO ______YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO ______YES. If you answered YES, please note the name of the entity and income generated from the entity. ______________________________

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

______NO X YES. If YES, please provide details. [illegible] has been paid [illegible] in connection with the Transaction.

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO ______YES. If YES, please provide details. ______________________________

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO ______YES. If YES, please provide details. ______________________________

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO ______YES. If YES, please provide details. ______________________________

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ _____

Signature Date

_____

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") (the "Transaction").

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) BHHCG and certain affiliates board members and officers; (ii) experts and consultants retained by BHHCG and its affiliates in connection with the Transaction; and (iii) senior executives at BHHCG and certain affiliates with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: TIMOTHY C. WINDENGEM

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: WINDENGEM CONSULTING
Title: PRESIDENT

_____ Bristol Hospital and Health Care Group, Inc.
Position(s): _____

_____ Bristol Hospital, Inc.
Position(s): _____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__√__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__√__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__√__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__√__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

X Timothy C. Wheatley 9/17/14
Signature Date

X Timothy
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) BHHCG and certain affiliates board members and officers; (ii) experts and consultants retained by BHHCG and its affiliates in connection with the Transaction; and (iii) senior executives at BHHCG and certain affiliates with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: THOMAS HAMLET

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:

Company Name: WONDERROOM CONSULTING

Title: VICE PRESIDENT CLIENT SERVICES

____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

____ Bristol Hospital, Inc.

Position(s): _____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9-17-2014
Date

THOMAS J. HANLEY
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

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Please provide the following information:

Print Name: Jeanine F. Reckdenwald

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Bristol Hospital and Health Care Group, Inc.

Position(s): Vice President Human Resources & Support Svcs

_____ Bristol Hospital, Inc.

Position(s): _____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. Definitions:

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

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

I am an employee of BHHCG. When the transaction closes I will become an employee of Tenet.

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

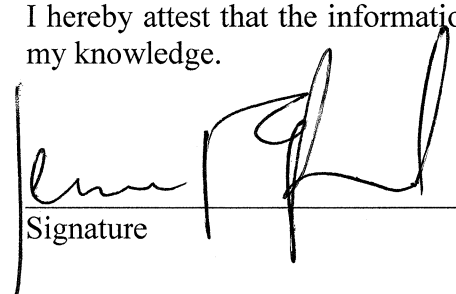
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

10-8-14

Date

Jeanine F. Reckdenwald

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

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Please provide the following information:

Print Name: Sheila Kempf

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

X Bristol Hospital, Inc.

Position(s): Sr VP Patient Care/CNO

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. I AM AN Employee of BHNC NOW AND will become AN Employee of Tenet at close of transaction

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/8/14
Date

Sheila Kempf, RN, PhD
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") (the "Transaction").

All Members and officers of the Board of Directors of BHHCG and certain affiliates, key employees, and experts and consultants retained by BHHCG must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) BHHCG and certain affiliates board members and officers; (ii) experts and consultants retained by BHHCG and its affiliates in connection with the Transaction; and (iii) senior executives at BHHCG and certain affiliates with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Ken Benoit

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): Director

_____ Bristol Hospital, Inc.

Position(s): Director

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Ken Benoit
Signature

9/15/14
Date

Ken Benoit
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Sharon Adler, MD

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

__✓__ Bristol Hospital and Health Care Group, Inc.

Position(s): board member - ned Staff rep

__✓__ Bristol Hospital, Inc.

Position(s): board member - ned Staff rep.

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. Definitions:

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

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✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

_____ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/15/14

Printed Name Sharon Allen

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: _____George Eighmy_____

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

__X____ Bristol Hospital and Health Care Group, Inc.

Position(s): ____Chief Financial Officer_____

___X___ Bristol Hospital, Inc.

Position(s): ____Chief Financial Officer_____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

____X_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

___X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

___X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X___ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

___X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

___X__ NO _____YES. If YES, please provide details. _____

I am an employee of BH/BHHCG. When the transaction closes, I will become an employee of Tenet.

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

___X__ NO _____YES. If YES, please provide details. _____

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__X___ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

___X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

___X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

George Eighmy
Signature

10/8/2014
Date

George Eighmy
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Christopher Bayle

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Bristol Hospital and Health Care Group, Inc.

Position(s): Director of Public Relations and Marketing

✓ Bristol Hospital, Inc.

Position(s): Director of Public Relations and Marketing

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. I am an employee of BH/BHHCO. When the transaction closes I will become an employee of Tenet.

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

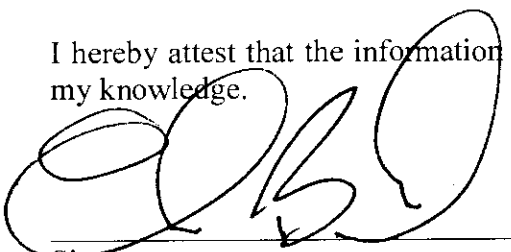
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

10/6/2014

Date

Christopher Boyle

Printed Name

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Please provide the following information:

Print Name: Susan Sylvester

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

_____ Bristol Hospital, Inc.

Position(s): _____

X Bristol Hospital Multispecialty Group, Inc.
Position(s): Assistant Vice President
Assistant Secretary to the BHMSG B.O.D

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__Y__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. I am an employee of BHMSG. When the transaction closes I will become an employee of Tenet. Susan Sylvestre

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Susan E. Sylvestre
Signature

9/15/2014
Date

Susan E. Sylvestre
Printed Name

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Please provide the following information:

Print Name: Ramiz Begdiseren

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

_____ Bristol Hospital, Inc.

Position(s): _____

✓ Bristol Hospital Multispecialty Group, Inc.
Position(s): Board member

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. I am an employee of BHMSG when the transaction closes, I will become an employee of Tenet

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/9/17
Date

Rainer Bagdasarian MD
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: VIJAY JOSHI, MD

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

_____ Bristol Hospital, Inc.

Position(s): _____

✓ Bristol Hospital Multispecialty Group, Inc.

Position(s): BOARD MEMBER

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

_✓_ 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 Tenet Entity or any YNHHSC Entity?

_✓_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. But as employee of BHMSG, I shall become Tenet employee when transaction is completed

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

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✓ NO _____ YES. If YES, please provide details. _____

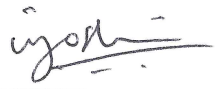
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

10/9/2014

Date

VIJAY JOSHI, MD

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: ___Mary Ann Cordeau

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

__X____ Bristol Hospital and Health Care Group, Inc.

Position(s): ____Board Member

___X___ Bristol Hospital, Inc.

Position(s): _____Board Member

_X_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____Board Member

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

___x___ NO_____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

___x___ NO_____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__x____ NO_____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

x

_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

x

_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__x____ NO_____YES. If YES, please provide details. _____

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_x_____ NO_____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__x____ NO_____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

___x___ NO_____YES. If YES, please provide details. _____
_____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__x____ NO_____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

10/13/19

_____ _____
Signature Date

Mary Ann Cordeau

_____
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: BALA SHANMUGAM

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

✓ Bristol Hospital and Health Care Group, Inc.

Position(s): Member of Board of directors

✓ Bristol Hospital, Inc.

Position(s): Chief of President of Medical Staff of Bristol Hospital.

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

When the transaction closes I will become an employee of Tenet

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

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✓ NO _____ YES. If YES, please provide details. _____

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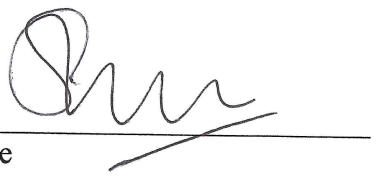
✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

9/25/14

Date

BALA SHANMUGAM.

Printed Name

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Please provide the following information:

Print Name: THOMAS H. MONAHAN

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

X Bristol Hospital and Health Care Group, Inc.

Position(s): Board Member

X Bristol Hospital, Inc.

Position(s): Board Member

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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_____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Thomas H Monahan
Signature

9/11/14
Date

THOMAS H. MONAHAN
Printed Name

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Please provide the following information:

Print Name: JOSEPH CHERNOSKIS, MD

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: N/A

Title: _____

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): N/A

_____ Bristol Hospital, Inc.

Position(s): N/A

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): Secretary

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X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

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X 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 Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. I AM AN EMPLOYEE OF BHMSG. WHEN THE TRANSACTION CLOSES I WILL BECOME AN EMPLOYEE OF TENET

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

____ NO ____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

____ NO ____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

____ NO ____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

____ NO ____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/16/14
Date

J. Christics MD
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") (the "Transaction").

All Members and officers of the Board of Directors of BHHCG and certain affiliates, key employees, and experts and consultants retained by BHHCG must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) BHHCG and certain affiliates board members and officers; (ii) experts and consultants retained by BHHCG and its affiliates in connection with the Transaction; and (iii) senior executives at BHHCG and certain affiliates with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Kenneth Rhee, MD.

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

✓ Bristol Hospital and Health Care Group, Inc.

Position(s): Chief Medical Officer.

_____ Bristol Hospital, Inc.

Position(s): _____

✓ Bristol Hospital Multispecialty Group, Inc.
Position(s): OB/GYN Physician

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO __✓__ YES. If YES, please provide details. I am an employee of BHMSG and BHHCG. When the transaction closes I would become an employee of Tenet.

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

9/15/14

Date

Kenneth Rhee, MD.

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

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Please provide the following information:

Print Name: James Cain

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: Cain Brothers
Title: Managing Director

_____ Bristol Hospital and Health Care Group, Inc.
Position(s): _____

_____ Bristol Hospital, Inc.
Position(s): _____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO __✓__ YES. If you answered YES, please note the name of the entity and income generated from the entity. We expect to be reimbursed by Tenet for an Unrelated engagement.

(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. Craig Brothers is the advisor to BHHCG

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO __✓__ YES. If YES, please provide details. See 3b

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_____ NO __✓__ YES. If YES, please provide details. See 3b

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO __✓__ YES. If YES, please provide details. See 3b

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ _____

Signature Date 11/5/14

James Cain

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Karen Guadagnini

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Bristol Hospital and Health Care Group, Inc.

Position(s): Board Member

X Bristol Hospital, Inc.

Position(s): Board Member

✓ Bristol Hospital Multispecialty Group, Inc.

Position(s): President

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. **Definitions:**

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

I am an employee of Bristol Hospital Multi-Specialty Group.
③ When the transaction closes I will become an employee of Tenet.

Karen Grindayner 10/9/14

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

__✓__NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Karen Gnadagnini
Signature

9/15/14
Date

Karen Gnadagnini
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

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Please provide the following information:

Print Name: James Cain

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: Cain Brothers
Title: Managing Director

_____ Bristol Hospital and Health Care Group, Inc.
Position(s): _____

_____ Bristol Hospital, Inc.
Position(s): _____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

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(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit B attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO __✓__ YES. If you answered YES, please note the name of the entity and income generated from the entity. Cain Brothers yearly retainer ON 11/13/14 to represent Tenet on their AR M&A assignment unrelated to BHHCG

(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. See Above

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_____ NO __✓__ YES. If YES, please provide details. In process

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO _____ YES. If YES, please provide details. See 3 b.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

11/13/14
Date

James Cain
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Chris McDonough

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:

Company Name: Cain Brothers

Title: Senior Vice President

_____ Bristol Hospital and Health Care Group, Inc.

Position(s): _____

_____ Bristol Hospital, Inc.

Position(s): _____

_____ Bristol Hospital Multispecialty Group, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than September 20, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Tenet Entity or any YNHHSC Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity. Cain Brothers was retained on 11/13/14 to represent Tenet on an M&A assignment unrelated to the BHHCG Transaction

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since January 1, 2012, were you or any Related Person offered a position as a director or trustee of a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a Tenet Entity or a YNHHSC Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since January 1, 2012, have you or any Related Person engaged in any of the following transactions with a Tenet Entity or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

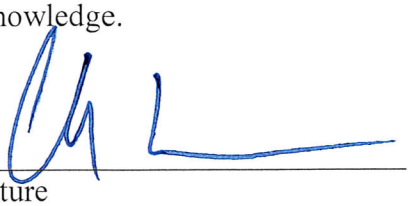
(iii) Been indebted to or loaned money to a Tenet Entity or a YNHHSC Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Facility or a YNHHSC Entity?

_____ NO X YES. If YES, please provide details. See 3b.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

11/13/14

Date

Chris McDonough

Printed Name

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 8: CONFLICT OF INTEREST DISCLOSURES - YNHHS

Conflict of Interest / Financial Disclosure Form

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Certain senior executives of YNHHSC 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 at YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: William J. Aseltyne
Position(s): Senior Vice President and General Counsel
Yale-New Haven Health Services Corporation

(b) Please complete and return this Disclosure Form no later than October 25, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

(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 Sandra Jarva Weiss of any such even or information as soon as possible.

2. Definitions:

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

(b) **Tenet Entity:** includes Tenet Healthcare Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **BHHCG Entity**: includes the following: Bristol Hospital and Health Care Group, Inc.; Bristol Hospital, Inc.; Bristol Hospital Multispecialty Group, Inc.; Bristol Hospital EMS, LLC; Bristol Health Care, Inc.; Ingraham Manor; Bristol Hospital Development Foundation, Inc.; Bristol MSO, LLC; Medworks, LLC; Connecticut Occupational Medicine Partners, LLC; MedConn Collection Agency, LLC; Total Laundry Cooperative, LLC; Central Connecticut Endoscopy Center, LLC and Health Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any BHHCG 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 Tenet Entity or any BHHCG Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any BHHCG 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 Tenet Entity, a BHHCG Entity, VHS Bristol Health System, LLC or the Local Hospital Board to be formed as part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Tenet Entity or a BHHCG Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Tenet Entity or a BHHCG Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Tenet Entity or a BHHCG Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

W. J. A. _____ Oct. 23, 2014

Signature Date

William J. Aseltyne

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale – New Haven Health Services Corporation ("YNHHSC") (the "Transaction").

Certain senior executives of YNHHSC 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 at YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Gayle Capozzalo
Position(s): Executive VP + Chief Strategy Officer
Yale-New Haven Health Services Corporation

(b) Please complete and return this Disclosure Form no later than October 25, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Tenet Entity or any BHHCG 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.

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(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 Tenet Entity or any BHHCG Entity?

_✓_ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

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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. _____

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(d) Do you or any Related Person own stock or options to purchase stock in any Tenet Entity or any BHHCG Entity?

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_____ NO _____ YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ _____

Signature Date

_____

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 at YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: James Staten
Position(s): Exec VP, Corporate & Financial Services
Yale-New Haven Health Services Corporation

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ 10/23/14
Signature Date

James Shaw
Printed Name

Conflict of Interest / Financial Disclosure Form

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Certain senior executives of YNHHSC 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 at YNHHSC who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Marna P. Borgstrom
Position(s): President + Chief Executive Officer
Yale-New Haven Health Services Corporation

(b) Please complete and return this Disclosure Form no later than October 25, 2014 to Kurt A. Barwis, President and CEO, BHHCG, Brewster Street, Bristol, CT 06011. If you have any questions regarding the Disclosure Form, please contact Sandra Jarva Weiss, at 484-765-2293.

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(iv) Furnished or acquired goods, services or facilities to a Tenet Entity or a BHHCG Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/22/14
Date

Marna P. Borgstrom
Printed Name

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 9: CONFLICT OF INTEREST DISCLOSURES – TENET, TENET HEALTHCARE CORPORATION CORPORATE GOVERNANCE PRINCIPLES

TENET HEALTHCARE CORPORATION
CORPORATE GOVERNANCE PRINCIPLES

The Board of Directors of Tenet Healthcare Corporation, acting on the recommendation of its Nominating and Corporate Governance Committee, has developed and adopted a set of corporate governance principles to promote a common set of expectations as to how the Board and its committees should perform their functions. These principles will be published on Tenet's corporate website and reviewed by the Board annually or more often as the Board deems appropriate.

1. Role of Board and Management. Tenet's business is conducted by its employees, managers and officers, under the direction of its Chief Executive Officer to enhance Tenet's long-term value for its shareholders. The Board is elected by the shareholders to oversee management and to monitor whether the long-term interests of the shareholders are being served. Both the Board and management recognize that the long-term interests of shareholders are advanced by responsibly addressing the concerns of other stakeholders and interested parties including patients, employees, physicians who practice at hospitals owned by Tenet's subsidiaries, lenders, bondholders, communities in which Tenet and its subsidiaries' hospitals do business, legislators, regulators and other government officials and the public at large.

2. Board Committees. The Board has established the following Committees to assist it in discharging its responsibilities: (i) Audit, (ii) Compensation, (iii) Nominating and Corporate Governance, (iv) Quality, Compliance and Ethics, and (v) Executive. Each Committee except the Executive Committee has a charter setting forth the key responsibilities of the Committee. Each Committee's charter is published on Tenet's corporate website and establishes independence standards for its members and is reviewed at least annually. Each Committee has a Chairperson who is nominated by the Nominating and Corporate Governance Committee and elected by the Board each year. Each Committee Chairperson reports the highlights of the meetings of his/her Committee to the full Board following each Committee meeting.

3. Functions of the Board and its Committees. Members of the Board and each Committee meet in person for regularly scheduled meetings and hold as many additional telephonic and in-person meetings as necessary to fulfill their responsibilities. At the Board and Committee meetings, Tenet's directors review, discuss, evaluate and ask questions of management and Board and Committee advisors concerning reports by management on Tenet's business strategy and long-term goals; financial and operating performance; financial condition; prospects, including competitive challenges and opportunities; and compliance and litigation. On at least an annual basis, the Board reviews its role and the roles of its Committees in the risk oversight of the Company. The Board and Committees also:

- Review, approve and monitor major corporate actions;
- Select the CEO and oversee the selection of Tenet's other executive officers;
- Evaluate and compensate Tenet's executive officers;

- Evaluate and approve a CEO succession plan;
- Assess major risks facing Tenet and review options for their mitigation;
- Monitor the integrity of Tenet's accounting, financial reporting and finance processes and systems of internal controls; and
- Review and monitor the processes in place for maintaining Tenet's ethical conduct, the quality of care provided at hospitals owned by Tenet's subsidiaries and compliance with laws and regulations.

4. **Size of Board and Selection Process.** The Nominating and Corporate Governance Committee is responsible for recommending, and the Board is responsible for selecting, the individuals to stand for election at each annual meeting. The Nominating and Corporate Governance Committee is also responsible for recommending, and the Board is responsible for selecting, the individuals to fill vacancies on the Board. Shareholders also may propose nominees for election to the Board in accordance with Tenet's Bylaws, which may be found on Tenet's website. Tenet's Bylaws require that Tenet have between 8 and 15 directors with the exact number set by the Board.

The Nominating and Corporate Governance Committee and the Board consider, among other things, the following attributes and criteria when selecting new nominees for election to the Board and determining which of Tenet's existing directors will stand for re-election to the Board: experience, skills, expertise, diversity, personal and professional integrity, character, business judgment, time availability in light of other commitments, dedication, conflicts of interest and such other factors as the Board considers appropriate In the context of its needs.

5. **Director Qualifications and Expectations.** Incumbent directors are not automatically re-nominated to stand for election. Each year, the Nominating and Corporate Governance Committee and Board will carefully consider each director's qualifications and contributions to the Board and make an informed decision as to which directors will stand for election.

Tenet's directors receive, and are expected to review, Board and Committee materials from management and the Board's and Committees' independent advisors in advance of all meetings. Directors are expected to attend all meetings of the Board and all meetings of the Committees on which they serve, and they are required to attend at least 75% of all regularly scheduled Board and Committee meetings.

Directors who serve as CEOs or in equivalent positions of public companies may not serve on the boards of more than two public companies in addition to Tenet's Board, and other directors may not serve on the boards of more than three public companies in addition to Tenet's Board. At the request of a director, the Chair of the Nominating and Corporate Governance Committee may waive the three board limit for a non-CEO director in a particular situation, upon a showing that additional board service would not impair the director's service on the Tenet Board.

No two Tenet directors may serve together on the board of any public company other than Tenet. Directors are expected to offer their resignation in the event of any significant change in their principal job responsibilities.

6. **Independence of Directors.** Two-thirds of the Board will consist of "independent" directors. The Board will not consider a director to be independent unless the Board affirmatively determines that the director has no material relationship with Tenet, and the director otherwise qualifies as independent under the corporate governance standards of the New York Stock Exchange.

7. **Independence of Committee Members.** The members of the Audit, Compensation and Nominating and Corporate Governance Committees shall meet the independence standards of the NYSE. In addition, the members of the Audit Committee shall meet the SEC independence standards for audit committee members.

8. **Non-Executive Chairman or Lead Director.** The Board will designate an independent, non-employee director as Chairman of the Board or, in the event that the Board desires to elect a member of management or a non-independent director to the Board and to appoint such individual as Chairman of the Board, the independent directors of the Board will designate an independent, non-employee director as Lead Director. The Lead Director will have a term of at least one year. The duties of the Lead Director will include, but not be limited to, (i) presiding at all meetings of the Board at which the Chairman is not present, (ii) chairing executive sessions of the Board, (iii) serving as the liaison between the independent directors and the Chairman, (iv) approving the information sent to the Board and meeting agendas and schedules, (v) having the authority to call meetings of the independent directors and (vi) representing the Board in meetings with investors, legislators, regulators and other government officials. The Lead Director, in conjunction with the Nominating and Corporate Governance Committee, also will take a role in the Board performance evaluation process.

9. **Executive Sessions.** Following every regularly scheduled Board meeting and at least once each fiscal quarter, the independent directors of the Board will meet in executive session without management present and, in the event there is an executive Chairman, the Lead Director will preside at such meetings. The independent directors may meet in executive session at such other times as determined by the Chairman and/or Lead Director. The Committees of the Board shall meet in executive session as prescribed in each Committee's charter. Each Committee of Tenet's Board regularly meets in executive session.

10. **Board Performance Evaluation.** The Nominating and Corporate Governance Committee will conduct an annual performance evaluation to determine whether the Board, its Committees and individual directors are functioning well in view of their responsibilities and Tenet's business. The results of the evaluation will be reviewed by the Chairman and/or the Lead Director who will report the results to the Board. As part of the annual performance evaluation process, each Committee will compare its performance with the requirements of its charter.

11. **Ethics and Conflicts of Interest.** The Board expects the directors, as well as all officers and other employees, to act ethically at all times and to acknowledge their

adherence to the policies comprising Tenet's *Standards of Conduct*. If an actual or potential conflict of interest arises for a director, the director shall promptly inform the Chairman of the Board and/or the Lead Director. If a significant conflict exists and cannot be resolved, the director should resign. All directors will recuse themselves from any discussion or decision affecting their personal, business or professional interests. The Quality, Compliance and Ethics Committee shall resolve any conflict of interest question involving directors or executive officers.

12. Reporting Concerns to the Audit Committee. Anyone who has a concern about Tenet's conduct, or about its accounting, internal accounting controls or auditing matters, may communicate that concern to the Audit Committee by calling Tenet's Ethics Action Line at 1-800-8-ETHICS (1-800-838-4427). Such communications may be confidential or anonymous. All such concerns will be forwarded to the Audit Committee for its review and will be simultaneously reviewed and addressed under the direction of Tenet's Chief Compliance Officer. The Audit Committee may direct special treatment, including the retention of outside advisors, for any concern addressed to it. Tenet's *Standards of Conduct* prohibit any employee from retaliating or taking any adverse action against anyone for raising or helping to resolve an ethical concern.

13. Shareholder Communications with the Board. Shareholders may communicate with the Board by e-mail to *boardofdirectors@tenethealth.com* or by writing to the Board c/o Corporate Secretary at Tenet's Dallas headquarters. Shareholder communications will be reviewed internally if the shareholder's concern can best be addressed by referral to a Tenet department such as Investor Relations or Corporate Communications. All other communications will be referred to the Corporate Secretary, who will determine if the communication should be brought to the attention of the full Board, the Chairman of the Board or a particular Board committee or Board member.

14. Compensation of Board. The Compensation Committee will conduct a review at least once every two years of the components and amount of Board compensation in relation to other similarly situated companies and make a report to the Board. Board compensation will be consistent with market practices and will be set at a level that does not call into question the Board's objectivity.

15. Stock Ownership and Retention Requirements. Each Tenet director with more than one year of service on the Board is required to own shares of Tenet's common stock. In addition, each director is required within five years of becoming a member of the Board, to own shares of Tenet's common stock with a market value equal to five times the director's annual retainer. Each of Tenet's senior officers is required to own shares of Tenet's common stock with a market value equal to a specific multiple of such senior officer's base salary as indicated in the table below. Each senior officer must meet the stock ownership requirements within five years from the date on which he or she becomes a senior officer. If, during or after such five-year period, a senior officer is promoted to a position that requires a higher stock ownership multiple than the position previously held, the senior officer will be granted an additional two-year period to meet the increased multiple.

Executive Level	Market Value of Common Stock Owned as a Multiple of Base Salary
Chief Executive Officer	6x
President	4x
Executive Vice President/Others above SVP	2x
Senior Vice President	1x

Shares counted toward the director and senior officer stock ownership requirements include: (i) shares of common stock held of record or in a brokerage account by the individual or his or her spouse; (ii) restricted stock or restricted stock units; (iii) stock units issued under deferred compensation plans; and (iv) any other security designated by Tenet's Nominating and Governance Committee as counting toward the guidelines.

If a director or senior officer does not meet the applicable ownership requirements, he or she must retain and hold 100% of any "net shares" received upon the exercise of stock options and the vesting of restricted stock or restricted stock units until such time as the director or senior officer meets such requirements. For purposes of this section, "net shares" means the number of shares received upon exercise of stock options or upon vesting of restricted stock or restricted stock units less the number of shares sold or deducted to pay the exercise price (in the case of options), withholding taxes and any brokerage commissions.

16. CEO Evaluation; Succession Plan. At least annually, the Board will conduct an evaluation of the CEO and review a succession plan for the CEO.

17. Contact with Management and Operations. All directors are encouraged to contact the CEO and other members of management at any time to discuss any aspect of Tenet's business. The Board will have frequent opportunities for directors to meet with the CEO and other members of management in Board and Committee meetings and in other formal and informal settings. Directors are expected to visit at least one Tenet hospital each year.

18. Access to Independent Advisors. The Board and its Committees have the authority and the funding to retain, at any time, independent outside financial, legal or other advisors. All such advisors are chosen by, and report directly to, the Board or the respective Committee.

19. Director Retirement. Directors will not be nominated for election to the Board after their 75th birthday.

20. Majority Voting Policy. Tenet's Bylaws provide for majority voting in the uncontested election of directors and plurality voting in contested elections. In uncontested elections, directors are elected by a majority of the votes cast, which means that the number of shares voted "for" a director must exceed the number of shares voted "against" that director. The Nominating and Corporate Governance Committee has established procedures for any director who is not elected to tender his or her resignation. The Nominating and Corporate Governance Committee will recommend to the Board whether to accept or reject the resignation offer, or whether other action should be taken.

In determining whether to recommend that the Board accept any resignation offer, the Nominating and Corporate Governance Committee will be entitled to consider all factors believed relevant by the Committee's members. The Board will act on the Nominating and Corporate Governance Committee's recommendation within ninety (90) days following certification of the election results. In deciding whether to accept the resignation offer, the Board will consider the factors considered by the Nominating and Corporate Governance Committee and any additional information and factors that the Board believes to be relevant. Thereafter, the Board will promptly publicly disclose its decision regarding the director's resignation offer (including the reason(s) for rejecting the resignation offer, if applicable). If the Board accepts a director's resignation offer pursuant to this process, the Nominating and Corporate Governance Committee will recommend to the Board and the Board will thereafter determine whether to fill such vacancy or reduce the size of the Board. Any director who tenders his or her resignation pursuant to this provision will not participate in the proceedings of either the Nominating and Corporate Governance Committee or the Board with respect to his or her own resignation offer.

21. Director Orientation. New directors participate in an orientation process. That orientation process will include background materials on Tenet, its business, strategic plans and goals, prospects and risk profile, and meetings with senior management.

22. Continuing Education. Each director is expected to attend a continuing education program related to their responsibilities as a director at least once every two years.

23. Amendment. These corporate governance principles shall not be amended except upon the approval of a majority of Tenet's independent Board members or as otherwise required by law or regulation.

Conflict of Interest/Financial Disclosure Form

This Conflict of Interest/Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale–New Haven Health Services Corporation ("YNHHSC") (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: HAROLD H. PILGRIM, III
   Tenet Healthcare Corporation
   Position(s): SR. VICE PRESIDENT

   (b) Please complete and return this Disclosure Form no later than October 30, 2014, by e-mail to Collin Baron at 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 even or information as soon as possible.

2. **Definitions:**

   (a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person

or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **BHHCG Entity**: includes the following: Bristol Hospital and Health Care Group, Inc.; Bristol Hospital, Inc.; Bristol Hospital Multispecialty Group, Inc.; Bristol Hospital EMS, LLC; Bristol Health Care, Inc.; Ingraham Manor; Bristol Hospital Development Foundation, Inc.; Bristol MSO, LLC; Medworks, LLC; Connecticut Occupational Medicine Partners, LLC; MedConn Collection Agency, LLC; Total Laundry Cooperative, LLC; Central Connecticut Endoscopy Center, LLC and Health Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any BHHCG Entity or any YNHHSC Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any BHHCG Entity or any YNHHSC Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any BHHCG Entity or any YNHHSC 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital 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 BHHCG Entity, or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a BHHCG Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a BHHCG Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a BHHCG Entity or a YNHHSC Entity?

✓ NO _____ YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

Nov 11, 2014
Date

GIGI ALDRETE
11-11-14

NOTARY PUBLIC STATE OF TEXAS
GIGI ALDRETE
My Commission Expires
April 04, 2015

EXHIBIT A

YNHHSC Subsidiaries and Affiliates List

Northeast Medical Group, Inc.

(a) Northeast Medical Group, PLLC (NY)
(b) Northeast Medical Group ACO, LLC
(c) PriMed Gastroenterology, LLC

The New Clinical Program Development Corp.

Yale University

YNHH-MSO, Inc.

YNHH-Physicians Corp.

Yale – New Haven Community Medical Group, Inc.

Yale New Haven Hospital Inc.

(a) Yale-New Haven Medical Center, Inc.
(b) Northeast Pediatric Specialists, Inc.
(c) Connecticut Children's Medical Center
(d) Lukan Indemnity Company, Ltd.
(e) Caritas Insurance Company, Ltd.
(f) PrimaryNet of Connecticut, Inc.
(g) Yale-New Haven Ambulatory Services Corporation

    (i) Shoreline Surgery Center, LLC
    (ii) SSC II, LLC
    (iii) Connecticut CK Leasing, LLC
    (iv) Saint Raphael Dialysis Center Partnership

(h) Yale-New Haven Care Continuum Corporation
(i) York Enterprises, Inc.

    (i) Medical Center Pharmacy and Home Care Center, Inc. d/b/a Apothecary & Wellness Center
    (ii) Medical Center Realty, Inc.
    (iii) Century Financial Services, Inc.
    (iv) Century Management Services, Inc.

Bridgeport Hospital

(a) Southern Connecticut Health System Properties, Inc.

  (i) Bridgeport Renewal, LLC

(b) Bridgeport Hospital Foundation, Inc.
(c) Bridgeport Hospital Auxiliary, Inc.
(d) Surgery Center of Fairfield County, LLC

Greenwich Health Care Services, Inc.

(a) Greenwich Hospital

  (i) Greenwich Fertility and IVF Center, P.C.
  (ii) Greenwich Integrative Medicine, PC
  (iii) Greenwich Occupational Health Services of New Jersey, P.C.
  (iv) Greenwich Occupational Health Services of New York P.C.
  (v) 900 King Street Associates
  (vi) Greenwich Clinical Pathology Associates, LLC
  (vii) Greenwich Pathology Associates, LLC

(b) Greenwich Health Services, Inc.

  (i) Greenwich Pediatric Services, PC

(c) Greenwich Ambulatory Surgery Center, LLC

  (j) Orthopaedic & Neurosurgery Center of Greenwich, LLC

(d) The Perryridge Corp.

  (i) GH Realty Holding, LLC
  (ii) 2105 West Main Street Associates, LLC

The Greenwich Hospital Endowment Fund

Conflict of Interest/Financial Disclosure Form

This Conflict of Interest/Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale–New Haven Health Services Corporation ("YNHHSC") (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: Wilson Robinson
Tenet Healthcare Corporation
Position(s): Manager, Acquisition & Development

(b) Please complete and return this Disclosure Form no later than October 30, 2014, by e-mail to Collin Baron at 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 even or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person

or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **BHHCG Entity**: includes the following: Bristol Hospital and Health Care Group, Inc.; Bristol Hospital, Inc.; Bristol Hospital Multispecialty Group, Inc.; Bristol Hospital EMS, LLC; Bristol Health Care, Inc.; Ingraham Manor; Bristol Hospital Development Foundation, Inc.; Bristol MSO, LLC; Medworks, LLC; Connecticut Occupational Medicine Partners, LLC; MedConn Collection Agency, LLC; Total Laundry Cooperative, LLC; Central Connecticut Endoscopy Center, LLC and Health Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any BHHCG Entity or any YNHHSC Entity (see definitions above)?

_X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any BHHCG Entity or any YNHHSC Entity?

_X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any BHHCG Entity or any YNHHSC 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital Board to be formed as part of the Transaction?

X 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital 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 BHHCG Entity, or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a BHHCG Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a BHHCG Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a BHHCG Entity or a YNHHSC Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/31/2014
Date

EXHIBIT A

YNHHSC Subsidiaries and Affiliates List

Northeast Medical Group, Inc.

(a) Northeast Medical Group, PLLC (NY)
(b) Northeast Medical Group ACO, LLC
(c) PriMed Gastroenterology, LLC

The New Clinical Program Development Corp.

Yale University

YNHH-MSO, Inc.

YNHH-Physicians Corp.

Yale – New Haven Community Medical Group, Inc.

Yale New Haven Hospital Inc.

(a) Yale-New Haven Medical Center, Inc.
(b) Northeast Pediatric Specialists, Inc.
(c) Connecticut Children's Medical Center
(d) Lukan Indemnity Company, Ltd.
(e) Caritas Insurance Company, Ltd.
(f) PrimaryNet of Connecticut, Inc.
(g) Yale-New Haven Ambulatory Services Corporation

    (i) Shoreline Surgery Center, LLC
    (ii) SSC II, LLC
    (iii) Connecticut CK Leasing, LLC
    (iv) Saint Raphael Dialysis Center Partnership

(h) Yale-New Haven Care Continuum Corporation
(i) York Enterprises, Inc.

    (i) Medical Center Pharmacy and Home Care Center, Inc. d/b/a Apothecary & Wellness Center
    (ii) Medical Center Realty, Inc.
    (iii) Century Financial Services, Inc.
    (iv) Century Management Services, Inc.

Bridgeport Hospital

(a) Southern Connecticut Health System Properties, Inc.

  (i) Bridgeport Renewal, LLC

(b) Bridgeport Hospital Foundation, Inc.
(c) Bridgeport Hospital Auxiliary, Inc.
(d) Surgery Center of Fairfield County, LLC

Greenwich Health Care Services, Inc.

(a) Greenwich Hospital

  (i) Greenwich Fertility and IVF Center, P.C.
  (ii) Greenwich Integrative Medicine, PC
  (iii) Greenwich Occupational Health Services of New Jersey, P.C.
  (iv) Greenwich Occupational Health Services of New York P.C.
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  (vii) Greenwich Pathology Associates, LLC

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  (i) Greenwich Pediatric Services, PC

(c) Greenwich Ambulatory Surgery Center, LLC

  (j) Orthopaedic & Neurosurgery Center of Greenwich, LLC

(d) The Perryridge Corp.

  (i) GH Realty Holding, LLC
  (ii) 2105 West Main Street Associates, LLC

The Greenwich Hospital Endowment Fund

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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: Erik Wexler
Tenet Healthcare Corporation
Position(s): CEO, Northeast Region

(b) Please complete and return this Disclosure Form no later than October 30, 2014, by e-mail to Collin Baron at 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 even or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person

or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **BHHCG Entity**: includes the following: Bristol Hospital and Health Care Group, Inc.; Bristol Hospital, Inc.; Bristol Hospital Multispecialty Group, Inc.; Bristol Hospital EMS, LLC; Bristol Health Care, Inc.; Ingraham Manor; Bristol Hospital Development Foundation, Inc.; Bristol MSO, LLC; Medworks, LLC; Connecticut Occupational Medicine Partners, LLC; MedConn Collection Agency, LLC; Total Laundry Cooperative, LLC; Central Connecticut Endoscopy Center, LLC and Health Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any BHHCG Entity or any YNHHSC Entity (see definitions above)?

__X__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any BHHCG Entity or any YNHHSC Entity?

__X__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any BHHCG Entity or any YNHHSC 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital Board to be formed as a part of the Transaction?

__N__ 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 BHHCG Entity, or a YNHHSC Entity?

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__N__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a BHHCG Entity or a YNHHSC Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a BHHCG Entity or a YNHHSC Entity?

__X__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a BHHCG Entity or a YNHHSC Entity?

__X__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

10/27/14
Date

EXHIBIT A

YNHHSC Subsidiaries and Affiliates List

Northeast Medical Group, Inc.

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(b) Northeast Medical Group ACO, LLC
(c) PriMed Gastroenterology, LLC

The New Clinical Program Development Corp.

Yale University

YNHH-MSO, Inc.

YNHH-Physicians Corp.

Yale – New Haven Community Medical Group, Inc.

Yale New Haven Hospital Inc.

(a) Yale-New Haven Medical Center, Inc.
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(b) Bridgeport Hospital Foundation, Inc.
(c) Bridgeport Hospital Auxiliary, Inc.
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  (ii) Greenwich Integrative Medicine, PC
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  (iv) Greenwich Occupational Health Services of New York P.C.
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  (vii) Greenwich Pathology Associates, LLC

(b) Greenwich Health Services, Inc.

  (i) Greenwich Pediatric Services, PC

(c) Greenwich Ambulatory Surgery Center, LLC

  (j) Orthopaedic & Neurosurgery Center of Greenwich, LLC

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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: Jeffry M. Peters
Tenet Healthcare Corporation
Position(s): Senior Counsel

(b) Please complete and return this Disclosure Form no later than October 30, 2014, by e-mail to Collin Baron at 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 even or information as soon as possible.

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or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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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 BHHCG Entity or any YNHHSC Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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(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 BHHCG Entity or any YNHHSC Entity?

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any BHHCG Entity or any YNHHSC 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital Board to be formed as part of the Transaction?

_____ NO _X_ YES. If YES, please provide details. If the transaction is completed, I may serve as a director of any wholly owned Trust subsidiaries in the chain of ownership (uncompensated role)

(b) Since January 1, 2012, were you or any Related Person offered a consulting position or employment with a BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital Board to be formed as a part of the Transaction?

_X_ NO _____ YES. If YES, please provide details. _____

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_X_ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a BHHCG Entity or a YNHHSC Entity?

_X_ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a BHHCG Entity or a YNHHSC Entity?

_X_ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a BHHCG Entity or a YNHHSC Entity?

_X_ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

Date 10/24/14

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Yale – New Haven Community Medical Group, Inc.

Yale New Haven Hospital Inc.

(a) Yale-New Haven Medical Center, Inc.
(b) Northeast Pediatric Specialists, Inc.
(c) Connecticut Children's Medical Center
(d) Lukan Indemnity Company, Ltd.
(e) Caritas Insurance Company, Ltd.
(f) PrimaryNet of Connecticut, Inc.
(g) Yale-New Haven Ambulatory Services Corporation

    (i) Shoreline Surgery Center, LLC
    (ii) SSC II, LLC
    (iii) Connecticut CK Leasing, LLC
    (iv) Saint Raphael Dialysis Center Partnership

(h) Yale-New Haven Care Continuum Corporation
(i) York Enterprises, Inc.

    (i) Medical Center Pharmacy and Home Care Center, Inc. d/b/a Apothecary & Wellness Center
    (ii) Medical Center Realty, Inc.
    (iii) Century Financial Services, Inc.
    (iv) Century Management Services, Inc.

Bridgeport Hospital

(a) Southern Connecticut Health System Properties, Inc.

(i) Bridgeport Renewal, LLC

(b) Bridgeport Hospital Foundation, Inc.
(c) Bridgeport Hospital Auxiliary, Inc.
(d) Surgery Center of Fairfield County, LLC

Greenwich Health Care Services, Inc.

(a) Greenwich Hospital

(i) Greenwich Fertility and IVF Center, P.C.
(ii) Greenwich Integrative Medicine, PC
(iii) Greenwich Occupational Health Services of New Jersey, P.C.
(iv) Greenwich Occupational Health Services of New York P.C.
(v) 900 King Street Associates
(vi) Greenwich Clinical Pathology Associates, LLC
(vii) Greenwich Pathology Associates, LLC

(b) Greenwich Health Services, Inc.

(i) Greenwich Pediatric Services, PC

(c) Greenwich Ambulatory Surgery Center, LLC

(j) Orthopaedic & Neurosurgery Center of Greenwich, LLC

(d) The Perryridge Corp.

(i) GH Realty Holding, LLC
(ii) 2105 West Main Street Associates, LLC

The Greenwich Hospital Endowment Fund

Conflict of Interest/Financial Disclosure Form

This Conflict of Interest/Financial Disclosure Form is being completed as part of the Bristol Hospital and Health Care Group Inc.'s ("BHHCG") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of BHHCG and its affiliates ("BHHCG") to VHS Bristol Health System, LLC, a to-be-formed, for profit entity owned by a joint venture between Tenet Healthcare Corporation ("Tenet") and Yale–New Haven Health Services Corporation ("YNHHSC") (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: Keith B. Pitts
Tenet Healthcare Corporation
Position(s): Vice Chairman

(b) Please complete and return this Disclosure Form no later than October 30, 2014, by e-mail to Collin Baron at 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 even or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person

or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **YNHHSC Entity:** includes Yale-New Haven Health Services Corporation and the subsidiaries and affiliates listed on Exhibit A attached to this form.

(c) **BHHCG Entity**: includes the following: Bristol Hospital and Health Care Group, Inc.; Bristol Hospital, Inc.; Bristol Hospital Multispecialty Group, Inc.; Bristol Hospital EMS, LLC; Bristol Health Care, Inc.; Ingraham Manor; Bristol Hospital Development Foundation, Inc.; Bristol MSO, LLC; Medworks, LLC; Connecticut Occupational Medicine Partners, LLC; MedConn Collection Agency, LLC; Total Laundry Cooperative, LLC; Central Connecticut Endoscopy Center, LLC and Health Connecticut, LLC.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any BHHCG Entity or any YNHHSC Entity (see definitions above)?

__✓__ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since January 1, 2012, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any BHHCG Entity or any YNHHSC Entity?

__✓__ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any BHHCG Entity or any YNHHSC 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital 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 BHHCG Entity, a YNHHSC Entity, VHS Bristol Health System, LLC or the Local Hospital 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 BHHCG Entity, or a YNHHSC Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a BHHCG Entity or a YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a BHHCG Entity or a YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a BHHCG Entity or a YNHHSC Entity?

__✓__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature 

Date 11/12/14

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 10: PRINCIPLE VALUATION'S QUALIFICATIONS AND CONFLICT DISCLOSURE

FAIR MARKET VALUATION ENGAGEMENT RESPONSE

December 27, 2012

HEALTHCARE FINANCE

EXECUTIVE SUMMARY

- Raymond James | Morgan Keegan is pleased to present our qualifications to provide a fairness opinion (the "Fairness Opinion") to the Board of Trustees (the "Board") of the Greater Bristol Hospital and Health Care Group, Inc. and its affiliates (together "BHHCG") in connection with the proposed sale (the "Transaction") to Vanguard Health Systems.
- We firmly believe that we are best qualified to deliver BHHCG a Fairness Opinion that will provide thoughtful analysis, technical rigor and clear communication, creating a strong fact pattern for the Board in demonstrating its obligations to the community.
- Raymond James | Morgan Keegan is a nationally recognized investment banking firm with an outstanding reputation and extensive experience advising not-for-profit hospitals, especially with respect to affiliations with for-profit entities.
- We will utilize a highly experienced team of senior bankers with more than 50 years of combined not-for-profit hospital experience that will be directly involved in all aspects of the engagement.
- Our credentials include more than two dozen fairness opinions over the last several years including:
  - Fairness opinion for Coffee Medical Group (not-for-profit) regarding its sale to Regional Care Hospital Partners (for-profit);
  - Fairness opinion for Hackensack University Medical Center (not-for-profit) regarding its joint venture with Legacy Hospital Partners (for-profit); and
  - Advising the New York Public Asset Fund regarding the conversion of EmblemHealth from a not-for-profit to a for-profit.
- We have also advised on numerous healthcare M&A transactions totaling more than $15 billion in value with many of these transaction involving not-for-profit hospitals. Our healthcare M&A expertise will translate to greater understanding, credibility and transaction scrutiny in conducting the Fairness Opinion.

EXECUTIVE SUMMARY (CONT'D)

- Through this vast work with not-for-profit organizations, we have a strong appreciation and understanding of evaluating an affiliation based on intangible considerations such as value to community and ensuring perpetuation of mission in addition to strictly monetary factors.
  - Included on page 16 is an outline of "The Five C's" (Clinical, Commitment, Community, Culture and Control) we recommend as criteria to evaluate whether a particular partnership is appropriate for an organization serving its community.
- Our independence will benefit the Board.
  - We eliminate the appearance of any conflict of interest but still know the markets, buyers and deal structures to expertly analyze the fairness of the Transaction. We also bring a highly recognized brand with numerous accolades and a leading reputation.
  - Our experience with the regulatory process assures that any public review of the Transaction will go smoothly.
  - We are also prepared to appear before any regulatory body, as requested by BHHCG, to discuss our report and the analysis underlying it.
- We are ready to commence the engagement immediately and are highly confident in our ability to complete the work in a tight time frame consistent with BHHCG's objectives.
- We look forward to your response. Should you have any comments or questions please feel free to call Joe Beck (914-419-6658) or Richard Lorenti (917-363-7848).

TABLE OF CONTENTS

Section 1		Firm Overview and Relevant Experience
Section 2		Biographies and Commitment of Proposed Team Members
Section 3		Diligence Needs
Section 4		Process Timeline
Section 5		Outline of Other Logistics & Coordination
Section 6		Compensation Structure
Section 7		Disclosure of Any Conflicts of Interest

SECTION 1A

Firm Overview

OUR FIRM: "BULGE BRACKET" RESOURCES, "BOUTIQUE" DEDICATION

Raymond James | Morgan Keegan offers a unique investment banking platform, combining the resources of a full-service investment bank with the senior-level dedication and experience of a health care boutique.

Boutique Investment Banks

- Limited capabilities and capital base
- Small-cap focus
- Relationship-dependent
- Senior-level attention
- Product-centric business model
- Unintegrated services platform
- Limited client coverage

RAYMOND JAMES®

- Full-service investment bank with deep resources
- Research and strategic advisory orientation
- Middle market focus
- Creative and relationship-oriented
- Superior senior-level attention and in-depth sector knowledge
- Transaction execution led by industry-focused teams
- Advisory services for all stages of company life cycle
- Extensive capital markets relationships

Bulge Bracket Investment Banks

- Broad range of products and services
- Strong institutional distribution capabilities
- Large-cap focus
- Commodity-oriented
- Balance sheet-centric
- Limited involvement of industry specialists in transaction execution
- Wide ranging client bases

RAYMOND JAMES OVERVIEW

CORPORATE HIGHLIGHTS

- Full-service securities firm **founded in 1962** and **public since 1983** ("RJF" on NYSE) with **14,000 employees**
- Fiscal 2011 revenue approximately **$3.3 billion**; net income over **$278 million**
- Total market capitalization of approximately **$4.6 billion**; client assets of approximately **$370 billion**

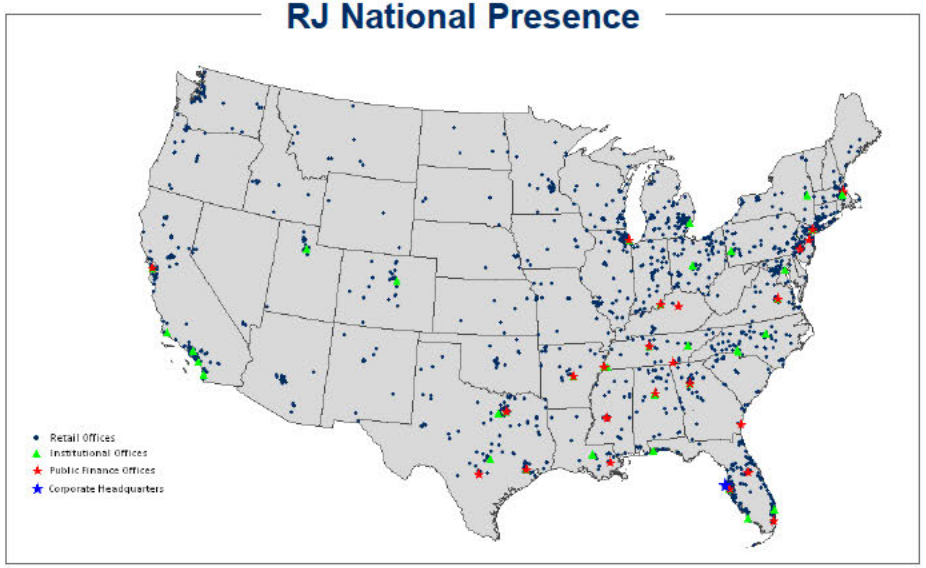
GEOGRAPHIC PRESENCE

- More than **2,900 offices** throughout the United States, Canada and overseas
- European operations in the United Kingdom, France, Belgium, Germany and Switzerland
- More than 20 North American and international investment banking and institutional sales offices

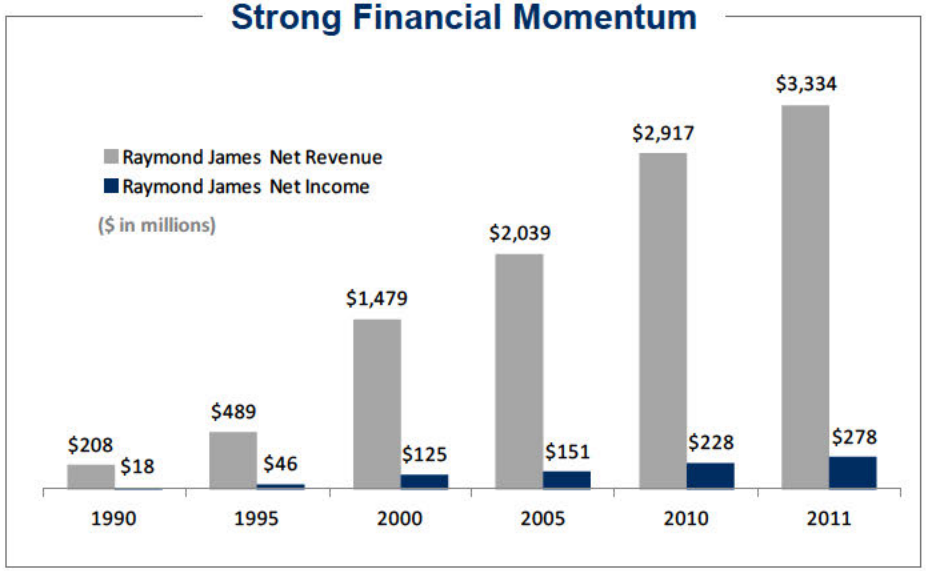
HIGHLY-RECOGNIZED BRAND WITH NUMEROUS ACCOLADES

- Ranked **2nd place** among all firms in the *Wall Street Journal's* "Best on the Street" research survey
- Ranked "**Highest in Investor Satisfaction** with Full Service Brokerage Firms" by J.D. Power & Associates
- Named "**Top Full-Service Broker**" in *SmartMoney*'s annual broker survey (2011)
- Ranked in the **top 5 "Most Admired" Securities Companies** by *Fortune* magazine (2011)
- "**Middle Market Investment Bank of the Year**" from *Buyouts Magazine* (2010)
- Named one of "**America's Most Trustworthy Companies**" by *Forbes* (2008)
- Named to *Forbes* list of **"400 Best Big Companies in America" for the 7th time** (2008)

RJ National Presence



Strong Financial Momentum



RAYMOND JAMES CORE BUSINESSES

INVESTMENT BANKING

- More than **230 professionals** organized by industry and transaction specialty
- Middle-market growth orientation focus
- **Completed more than 430 offerings** raising in excess of **$160 billion** in the past five years
- Completed nearly **300 M&A advisory assignments** totaling **more than $25 billion in value** in the past five years

EQUITY CAPITAL MARKETS

- One of Wall Street's leading equity research efforts with **95 fundamental and technical research analysts** covering nearly **1,000 U.S. and more than 300 international companies**
- **1,800 active institutional accounts**
- Global distribution capabilities - approximately **25% of institutional equity commissions generated in Europe**

FIXED INCOME CAPITAL MARKETS

- **5th ranked underwriter in Connecticut** and 9th ranked nationally through Q3 2012
- More than **225 experienced institutional salespersons** servicing more than **2,400 institutional accounts**
- More than **175 Fixed Income traders**
- More than **50 Fixed Income strategists** supporting clients
- **More than 180 Public Finance professionals** in 25 locations nationwide

RETAIL BROKERAGE

- Approximately **7,100 financial advisors** in 2,600 retail locations nationwide with nearly **1.9 million client accounts** in the U.S.
- More than **450 financial advisors** in **100 offices** in Canada
- **20 offices in 10 countries** internationally

ASSET MANAGEMENT

- **$72 billion in Assets Under Management** for both institutional and individual investors
- Eagle Asset Management - Pension and profit sharing, retirement funds, foundations
- Eagle Boston Investment - Small-Cap equity portfolios

RAYMOND JAMES BANK

- **$8.8 billion in Total Assets**
- Innovative Banking Services - Both lending and depository services offered across 50 states
- Letters and Lines of Credit
- Private Banking

OVERVIEW OF HEALTHCARE FINANCE GROUP

Raymond James | Morgan Keegan's Healthcare Finance Group provides a full spectrum of healthcare investment banking services while offering the focused attention and deep industry expertise of a specialty boutique.

- **History –** Morgan Keegan has long been recognized as a leader in capital markets transactions for the not-for-profit health care industry. In June 2007, Morgan Keegan acquired Shattuck Hammond Partners, a specialty healthcare boutique, to expand its breadth of capabilities to include both mergers and acquisitions and real estate advisory. With the merger with Raymond James in 2012, Raymond James has now assembled perhaps the largest healthcare banking group on or off the "Street" with a focus on not-for-profit healthcare.
- **Industry Expertise –** Long, rich history of providing client-focused investment banking and strategic advisory services for middle market public, private and not-for-profit healthcare companies across the country. Our dedicated focus throughout the healthcare continuum gives us a knowledge base unmatched by our competitors.
- **Track Record –** Lead investment banker on transactions totaling over $41 billion in asset value, including over $12 billion in M&A, $21 billion in Capital Markets, $8 billion in Real Estate transactions.
- **People –** 27 banking professionals in six offices: Chicago, Memphis, New York, Philadelphia, St. Louis and St. Petersburg.
- **Philosophy –** Objective, results-focused advice that starts with strategy. We strive to build long-term relationships based on value-added strategic capital advice and competitive market-driven execution.

Coverage Across the Healthcare Continuum

- Hospitals and healthcare systems
- Ambulatory surgery centers
- Behavioral health
- Clinical research organizations
- HCIT
- Home health
- Labs
- Long-term care
- Managed care
- MedTech
- Post acute
- Physician practice management

Full Spectrum Healthcare Banking Services

- Mergers & Acquisitions Advisory
- Real Estate Advisory
- Real Estate Monetization and Development
- Strategic Advisory
- Underwriting
- Private Placements
- Derivatives Structuring and Execution

HEALTHCARE FINANCE PROFESSIONALS

Raymond James | Morgan Keegan has assembled one of the largest and most qualified groups of investment bankers dedicated to the not-for-profit healthcare sector.

We have 26 dedicated healthcare professionals in six offices across the country.

Managing Directors

- Joseph G. Beck (NY)
- Steve Benov (IL)
- Jim Birdwell (TN)
- Jan Blazewski (PA)
- Michael S. Guernier (NY)
- Mitchell L. Kornblit (NY)
- Richard J. Lorenti (NY)
- Vinton L. Rollins (NY)

Senior Vice President

- Laca Wong Hammond (NY)
- Matthew M. Crosby (TN)

First Vice President

- Jeremy Lively (TN)

Vice Presidents

- Lorie Damon (MO)
- Sharon Ioannidis (FL)
- Vasanta B. Pundarika (NY)
- Amanda K. Verner (NY)
- Natalie Wabich (IL)

Associate Vice President

- Peter H. Delaney (NY)

Associate

- Michael P. Cacchio (NY)

HEALTHCARE FINANCE BANKING SERVICES

As bankers to the healthcare industry, our transaction execution services are combined with strategic advisory services.

Strategic Advisory

- Strategic options assessment
  - Corporate organization
  - Real estate
  - Capital finance
  - Strategic capital planning
- Debt policy development and education

Mergers & Acquisitions

- Acquisitions and divestitures
- Mergers, joint ventures and affiliations
- **Valuations and fairness opinions**
- Advised on over $12 billion in completed M&A transactions

Real Estate

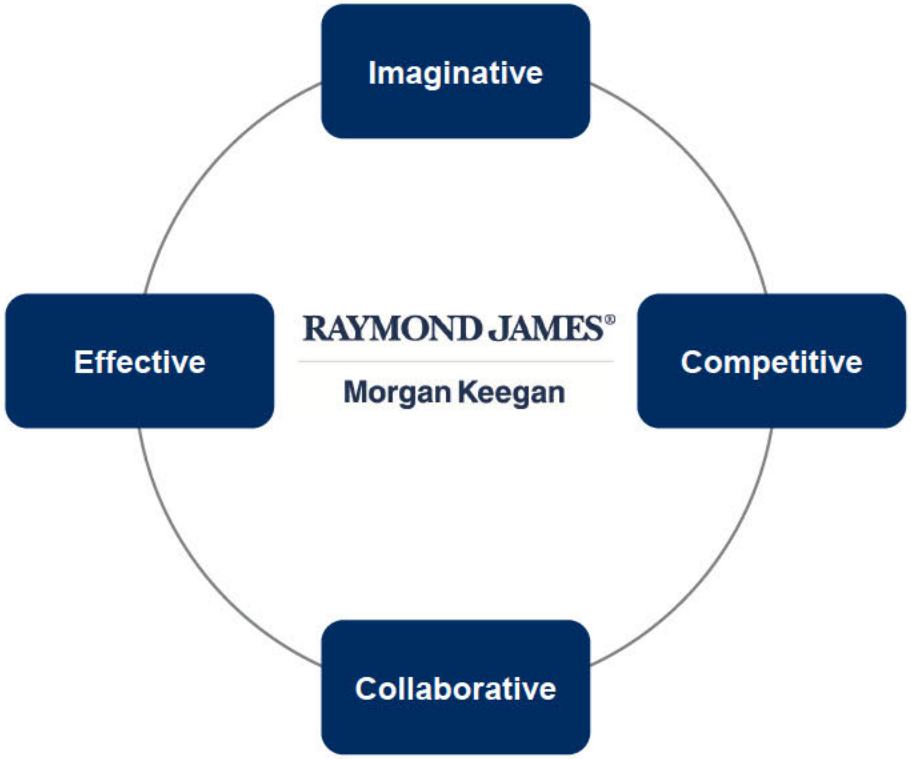
- Monetization of real estate assets
- Developer selection; project financing
- Advised on over $8 billion in completed Real Estate transactions

Capital Markets

- Over $21 billion in completed Capital Markets transactions for tax-exempt and taxable debt
- Debt restructurings and bankruptcy advisory
- Competitive bidding of investment products
- Structuring and principal execution for derivative transactions

COMMITMENT TO BUILDING LONG-TERM RELATIONSHIPS

We develop and execute creative operational and financial strategies to produce superior, lasting results for our clients. This philosophy guides everything we do – and drives us to approach each engagement with an eye towards a long-term relationship.



- **Understanding Client's Priority Objectives –** Understanding our client's long-term mission, business and financial objectives serves as the foundation for identifying potential strategic options for best achieving those objectives
- **Evaluating Strategic Options –** Assets and liabilities must be managed, within the context of each organization's unique situation, to support the organization's short and long-term objectives
- **Executing Selected Transactions –** Effective execution of selected strategic or financial transaction comes "after" thorough evaluation of client objectives and options
- **Senior Bankers –** Executing complex transactions and delivering maximum value for clients requires innovation and creativity that only experienced bankers can provide
- **Deep Platform and Sector Expertise –** Bankers have executed industry-precedent transactions across a broad spectrum of sectors
- **Commitment to Long-term Client Relationships –** Our focus and service is based on continuously building and earning a long-term relationship with our clients

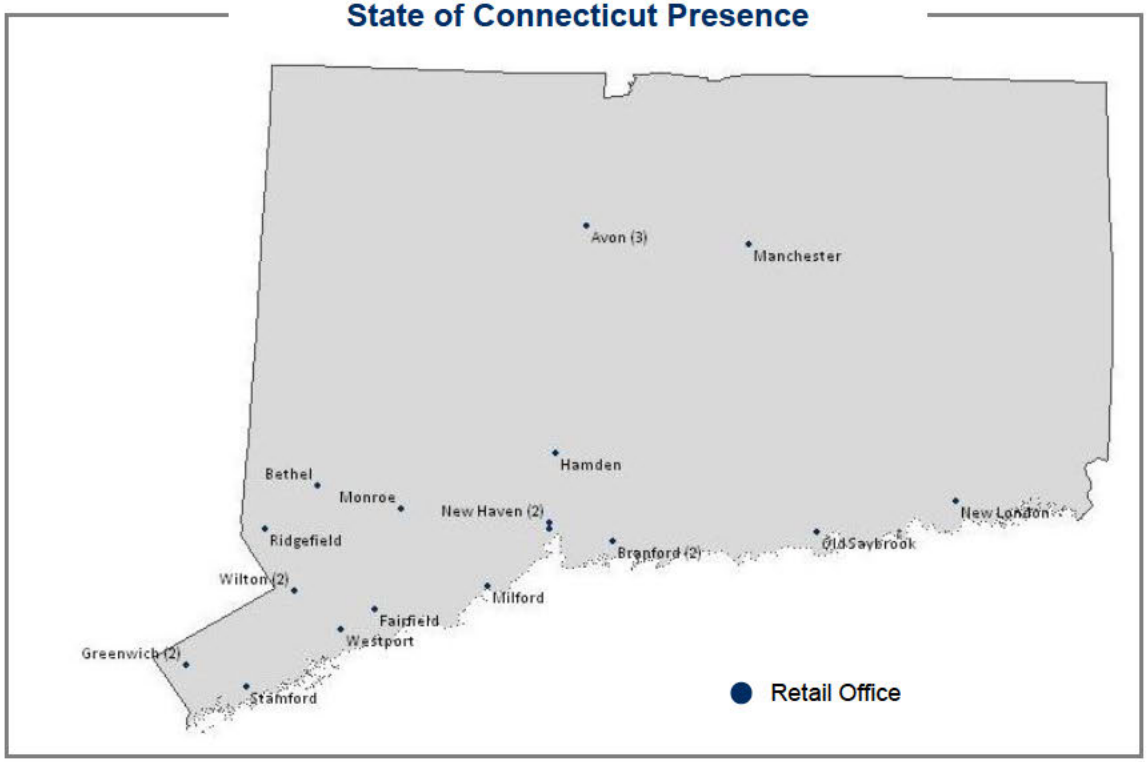
PREMIER NATIONAL HEALTH SYSTEM CLIENTS

Raymond James | Morgan Keegan Healthcare Finance has earned long-term client relationships with leading not-for-profit hospitals and health systems nationwide.

CONNECTICUT COMMITMENT

Raymond James | Morgan Keegan is committed to a strong business presence in Connecticut.

- In the state of Connecticut, the Firm has 78 retail brokers in 70 offices.
- These brokers manage 18,921 accounts with approximately $2.9 billion in client assets.
- Raymond James | Morgan Keegan is also the fifth ranked municipal underwriter in the state of Connecticut.
- These activities do not create any conflict of interest and do not present issues with BHHCG's exclusivity requirement outlined in the RFP.



SECTION 1B

Relevant Experience

OUR VALUE PROPOSITION

Raymond James | Morgan Keegan's Fairness Opinion will offer BHHCG thoughtful analysis, technical rigor and clear communication of not only the ultimate results, but also any unique nuances of the transaction.

- As an independent advisor conducting the Fairness Opinion, Raymond James | Morgan Keegan will facilitate Board transparency in its deliberations.
- Raymond James | Morgan Keegan's reputation and expertise in M&A translate to greater understanding, credibility and transaction scrutiny in conducting the Fairness Opinion.
- Raymond James | Morgan Keegan's independence will benefit the Board.
  - While we eliminate the appearance of any conflict of interest, we know the markets, buyers and deal structures to expertly analyze the fairness of the transaction.
  - Our fixed Fairness Opinion fees, independence and reputation will create a strong fact pattern for the Board in demonstrating fulfillment of its fiduciary obligations.
  - Our experience with regulators assures that any public review of the proposed transaction will go smoothly.
- Raymond James | Morgan Keegan would want to present to the Board preliminary conclussions with time for the Board to reflect on our analysis, ask questions and discuss the results in order to make informed decisions when entering into definitive agreement(s).
- All of these considerations assist the Board in appropriately executing its fiduciary responsibilities.

OTHER CRITERIA FOR EVALUATING AND STRUCTURING A TRANSACTION FOR NOT-FOR-PROFIT, COMMUNITY ORGANIZATIONS

We recognize the Fairness Opinion will evaluate the Transaction from a financial perspective; however, we acknowledge there are other attributes of a transaction a board may consider in weighing alternatives.

Clinical	■ Will the strategy enhance the organization's ability to provide high quality health services to the community – now and in the future? ■ Will physician recruitment and specialty care resources be enhanced? ■ How will potential consolidation of services in the organization affect the strategy?
Commitment	■ Will the strategy provide the appropriate level of financial commitment, capital or resources to ensure that the organization or its successor can serve the community with high quality care and facilities and be competitive with other market participants?
Community	■ Will the community at large understand and accept the strategy as being in the best interest of the organization and the community? Can the strategy be supported by its physicians, patients, government officials, payors, and the like?
Control	■ Will the strategy – on balance – afford the organization and its constituents adequate assurances, or control rights that community representatives can influence or assure, that the above "C's" are in place to serve the community in a responsive way going forward?
Culture	■ Will the strategic partnership provide the right culture or fit in line with the organization's mission, values and vision for the future? ■ Is there agreement on the near term business plan to avoid out-of-the-box disputes? ■ Will there be effective the organization leadership in key management, board and physician positions going forward?

SELECT HEALTHCARE FAIRNESS OPINION EXPERTISE

Fairness Opinion for HackensackUMC (Where medicine meets innovation) regarding its joint venture with Legacy Hospital Partners, Inc.

Fairness Opinion for Ministry Health Care regarding its acquisition of Affinity Health System from Wheaton Franciscan Healthcare

Fairness Opinion for CHG Coffee Health Group regarding its sale to RegionalCare Hospital Partners

Fairness Opinion for Novant Health regarding its acquisition of an equity interest in HMA

Fairness Opinion ** for Saint Mary's Health System regarding its joint venture with Legacy Hospital Partners, Inc.

Fairness Opinion for The Ochsner Clinic regarding its merger with The Alton Ochsner Medical Foundation to form Ochsner Clinic Foundation

Fairness Opinion for Hospital Sisters Health System regarding the acquisition of Prairie Cardiovascular

Fairness Opinion for Via Christi Health regarding its acquisition of an equity interest in Kansas Heart Hospital

Fairness Opinion for NorthPenn Hospital regarding its sale to UHS

Fairness Opinion for Mercy Health System regarding the sale of its 50% interest in AmeriHealth Mercy Health Plan and Keystone Mercy Health Plan to Independence Blue Cross

Fairness Opinion for Trinity Health regarding its sale of [redacted] to PriorityHealth

Fairness Opinion for selecticare regarding its sale to Health Alliance Plan of Michigan & PPOM

Fairness Opinion for Via Christi Health regarding its sale of Preferred Health Systems to Coventry Health Care

Fairness Opinion for Advocate Health Care regarding the sale of Ravenswood Medical Center to Seay & Thomas, Inc.

Fairness Opinion for healthfirst regarding its acquisition Senior Health Partners For Independent Living

Fairness Opinion for Ryan Network (William F. Ryan Community Health Network) regarding its sale of CenterC to New York State Catholic Health Plan, Inc. (dba Fidelis Care New York)

Fairness Opinion for SafeGuard Dental & Vision regarding its sale to a subsidiary of MetLife

Fairness Opinion for HARMONY Health Plan regarding the sale of its Medicaid HMO business to WellCare

Fairness Opinion for Newnan Hospital regarding the sale of its main hospital campus to Piedmont Hospital

Fairness Opinion for Georgetown University regarding the sale of its clinical business enterprise, including the University Medical Center to MedStar Health

Fairness Opinion for The Baptist Health System of East Tennessee regarding its merger with St. Mary's to form Mercy Health Partners

Fairness Opinion for Virginia Hospital Center (Arlington) regarding the sale of its continuing care retirement community to The Fountains

Fairness Opinion for Richardson Regional Medical Center regarding its 20 year operating lease agreement with Methodist Health System

Fairness Opinion for Community Health Corporation regarding the sale of its interest in Riverside Community Hospital to HCA (Hospital Corporation of America)

Note:Bold outline denotes transactions involving both not-for-profit and for-profit entities.

** Raymond James | Morgan Keegan is no longer engaged by St. Mary's Health System.

NOT-FOR-PROFIT / FOR-PROFIT HOSPITAL JOINT VENTURE

HackensackUMC Where medicine meets innovation | Legacy Hospital Partners, Inc.

Joint Venture Advisory

Financial Advisory and Fairness Opinion Services to Hackensack University Medical Center

Hackensack Acquisition of Pascack Valley Hospital – Strategy, Bankruptcy, JV Activities

Hackensack University Medical Center ("HUMC") retained Raymond James | Morgan Keegan to assist Board and Management in evaluating the possible acquisition of Pascack Valley Hospital ("PVH"), a 291-bed community hospital located in affluent Westwood, NJ. HUMC is generally recognized as northern New Jersey's leading medical center and one of metropolitan New York City's finest hospitals. HUMC is currently located in an older urban setting and viewed favorably a possible expansion into the suburban and upscale Northern Bergen County area which PVH occupied. HUMC had already entered into a preliminary letter of intent with PVH to acquire the hospital as Raymond James | Morgan Keegan was being retained.

Our Role as Financial Advisor

Raymond James | Morgan Keegan quickly took stock of the PVH opportunity from both a strategic and monetary viewpoint and concluded that PVH could not be "valued" at anywhere near its stated or implied liabilities and that an outright acquisition of PVH could jeopardize HUMC realizing its other strategic and financial initiatives. Raymond James | Morgan Keegan dissuaded HUMC from acquiring PVH as was originally contemplated and attempted to negotiate a beneficial transaction with PVH and its creditors so that HUMC could prudently execute on an acquisition or an initial affiliation.

Upon Raymond James | Morgan Keegan's advice to avoid rushing a transaction, HUMC was able to later acquire PVH out of a bankruptcy sale for a much reduced purchase price and assumed investment. The acquisition was initially accomplished with Touro College – its intended medical school partner. HUMC has opened a freestanding ER and mobile ICU in the PVH market and is evaluating with a for-profit hospital partner the re-development of a modern and fully equipped community hospital at the PVH site in order to protect market share, ensure referrals for its tertiary care business and enhance and diversify its financial / business profile. Raymond James | Morgan Keegan and HUMC negotiated the final funding, business and structural terms of the JV with its for-profit hospital partner. **Raymond James | Morgan Keegan also provided a Fairness Opinion to the HUMC Board.**

SALE OF NFP HEALTHCARE SYSTEM TO FOR-PROFIT ACQUIRER

$393,000,000

CHG
Coffee Health Group

was acquired by

RegionalCare
HOSPITAL PARTNERS

Financial Advisory and Fairness Opinion Services to Coffee Health Group

Coffee Health Group

Coffee Health Group ("CHG" or the "System") is a two-hospital system in northwest Alabama. The System had been experiencing below expectation operational and financial performance and carried a significant amount of debt as the result of an earlier acquisition. Declining profitability caused CHG to default under its Maximum Annual Debt Service Covenant. MBIA had provided bond insurance and was growing increasingly uncomfortable with the financial direction of the System.

Heading towards bankruptcy and in need of a capital partner, CHG engaged our firm to find a experienced partner that could best meet the needs of CHG and the community.

Our Role as Financial Advisor

We orchestrated an extensive process that eventually resulted in four proposals that retired 100% of the outstanding debt and delivered significant equity value. All four proposals approached 1.0x revenue in valuation, approximately the median for public hospital management companies and an impressive valuation for a hospital with declining profitability. At closing the outstanding bonds were trading at approximately $0.80 to $0.85 on the dollar.

RegionalCare Hospital Partners, a for-profit hospital company backed by private equity firm Warburg Pincus, submitted a proposal that included a purchase of the hospital, retirement of 100% of the bonds, and a commitment to build a replacement hospital. RegionalCare Hospital Partners was also in alignment with Coffee Health Group's strategic goals and clinical mission for the community. **Raymond James | Morgan Keegan provided a Fairness Opinion to the CHG Board in connection with the transaction.**

The aggregate transaction value approached 2.0x revenue, significantly above market valuation.

ACQUISITION OF HEALTH PLAN, HOSPITALS AND PHYSICIAN GROUP

Ministry Health Care

assumed sole sponsorship of

Affinity Health System

from

Wheaton Franciscan Healthcare

Financial Advisory and Fairness Opinion Services to Ministry Health Care

Ministry Health Care

Ministry Health Care ("Ministry") is a network of 15 hospitals, clinics, long-term care facilities, home care agencies, dialysis centers and other programs and services in Wisconsin and Minnesota. In 1996, Ministry partnered with Wheaton Franciscan Healthcare to form Affinity Health System ("Affinity"), a Wisconsin-based healthcare organization with over $1 billion in revenue. Affinity includes three hospitals, 26 clinics, and a medical group that includes nearly 300 providers. In addition, Affinity's businesses include Network Health Plan, a health plan serving more than 140,000 commercial and Medicare members in communities located throughout northeastern Wisconsin's 17 counties.

Our Role as Financial Advisor

We advised Ministry Health Care in creating the second largest healthcare organization in Wisconsin through the acquisition of Affinity Health System and Network Health Plan. Faced with an increasingly competitive environment and significant capital needs for Affinity, Ministry engaged Raymond James | Morgan Keegan to perform a Strategic Options Assessment with regard to Ministry's interest in Affinity, with a particular view toward Network Health Plan, which had recently converted from a closed model HMO to a broad provider network. As a result of our analysis and understanding of Ministry's goals and the challenges facing Wheaton Franciscan Healthcare, we advised Ministry to pursue an acquisition of sole ownership of Affinity. As acquisition advisor, we played an integral role in developing a valuation of approximately $300 million for Affinity, which incorporated the significant future capital needs of Affinity, and in evaluating financing options for the transaction. **We also provided a Fairness Opinion to Ministry's Board**. The acquisition closed in February 2012.

MERGERS & ACQUISITIONS ADVISORY SERVICES

Not-for-profit hospital M&A advisory is one of Raymond James | Morgan Keegan's principal competencies. Our reputation and experience in hospital M&A translate to greater understanding, credibility and transaction expertise in conducting the Fairness Opinion.

- Presently, Raymond James | Morgan Keegan is representing clients in numerous active not-for-profit healthcare M&A discussions across the country.
- We have represented or negotiated with major participants – both publicly traded and privately held – in all sectors of the healthcare services industry.
- Our substantial experience in developing innovative partnerships and transaction structures to achieve "core" client objectives benefits our clients when planning, evaluating and implementing M&A transactions.
  - Not-for-profit mergers, acquisitions and divestitures with not-for-profit parties
  - Not-for-profit mergers, acquisitions and divestitures with for-profit parties
  - Not-for-profit/for-profit joint ventures
  - Provider/managed care alliances
  - Hospital/physician alliances
  - Sector consolidations and "roll-ups"
  - Outsourcing transactions
  - Leases and management agreements

Raymond James | Morgan Keegan professionals bring creativity and commitment to each engagement – and invest the time required to get the right deal done.

SELECT RECENT HOSPITAL TRANSACTIONS

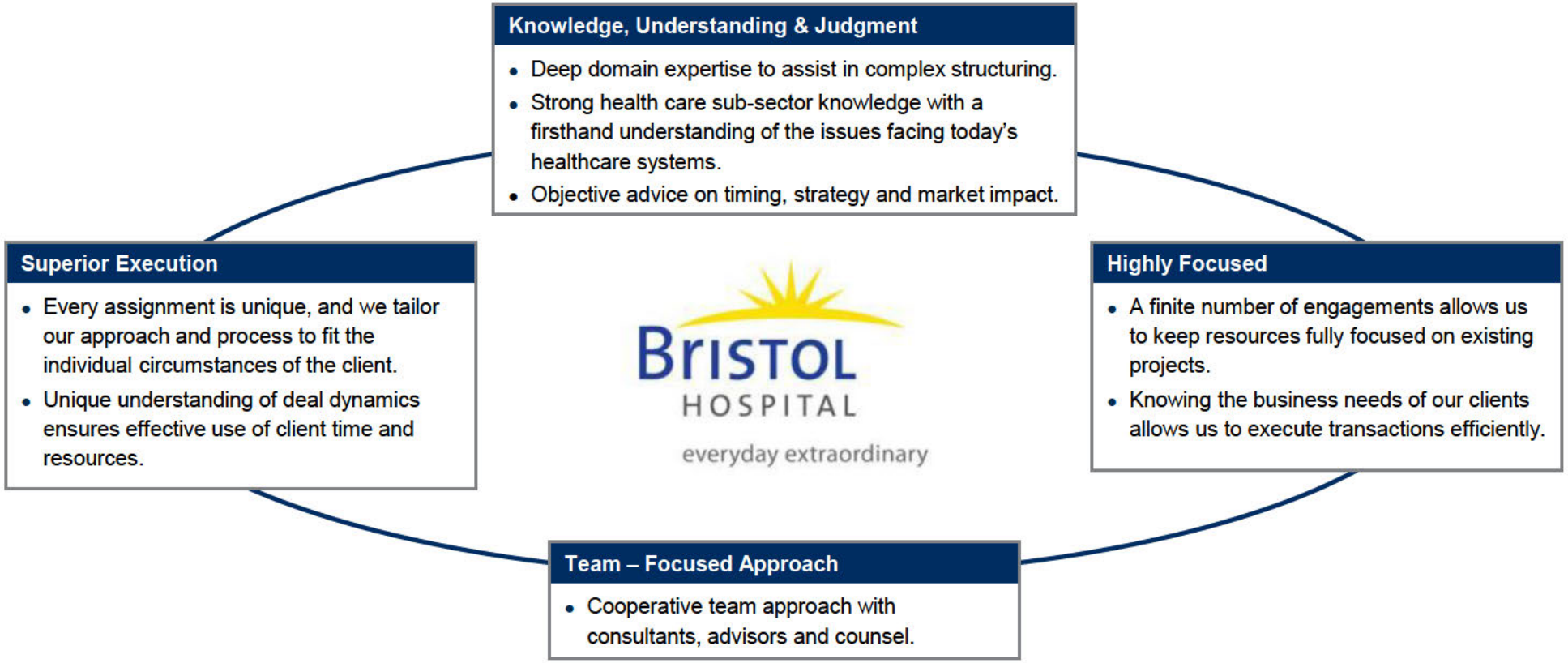
Ongoing Sale of Community Hospital in the Northeast **Advisor to Company**	Ongoing Hospital-Based Home Health Divestiture in Tri-State Area **Advisor to Company**	Ongoing Hospital Purchase of Medical Office Building in the Northeast **Advisor to Company**	Ongoing Sale advisory for Midwest Catholic Health System to National Catholic Health System **Advisor to Company**	February 2012 Ministry Health Care assumed sole sponsorship of Affinity Health System from Wheaton Franciscan Healthcare	December 2011 HackensackUMC sold its outpatient dialysis operations to DaVita.
June 2011 Trinity Health sold a 51% interest in Battle Creek Health System to Bronson	February 2011 MEDISTAR Sale of Long-Term Acute Care Hospital	February 2011 Hamot was sold to UPMC LIFECHANGINGMEDICINE	December 2010 Texas Health Resources acquired MedicalEdge Healthcare Group, PA and PhysServe Physician Services, Inc.	October 2010 Saint Vincent Catholic Medical Centers sold its behavioral health campus, St. Vincent's Westchester, to Saint Joseph's Medical Center	September 2010 $17,000,000 Saint Vincent Catholic Medical Centers sold its Certified Home Health Agency to North Shore LIJ sold its Long Term Home Health Care Program to VNSNY
July 2010 $393,000,000 CHG Coffee Health Group was sold to RegionalCare Hospital Partners	April 2010 Texas Health Resources has entered into a JV with Legacy Hospital Partners, Inc. and acquired WNJ Wilson N. Jones Medical Center	February 2010 Lake Forest Hospital merged with Northwestern Memorial Hospital	February 2010 Via Christi Health sold Preferred Health Systems to Coventry Health Care	December 2009 HackensackUMC sold its home health operations to Amedisys Home Health Services	October 2009 BayMedical Behavioral Health Center was sold to PSI
June 2009 Richardson Regional Medical Center signed a 20-year operating lease agreement and joined Methodist Health System	April 2009 Lake Forest Hospital acquired three facilities operated by GRC Gurnee Radiology Centers	February 2009 Siloam Springs Memorial Hospital was sold to CHS Community Health Systems	December 2008 Hospital Sisters Health System acquired Prairie Cardiovascular	March 2008 $300,000,000 Novant Health acquired a 27% interest in seven hospitals from HMA	March 2008 $19,700,000 **Sun Coast Hospital** was sold to HCA Hospital Corporation of America

SECTION 2

Biographies and Commitment of Proposed Team Members

TEAM BASED APPROACH

Raymond James | Morgan Keegan employs a team based approach combining various facets of our platform to deliver expert advice to hospitals and healthcare systems.



RAYMOND JAMES | MORGAN KEEGAN TEAM

Raymond James | Morgan Keegan has committed senior professional resources with vast experience involving hospital M&A to lead, and actively work on, the BHHCG engagement and accomplish BHHCG's objective in a timely matter.

	Banker	Contact Information	Prior Firms
Healthcare Finance Group	**Joseph G. Beck** *Managing Director* *Co-Head of Healthcare Finance*	630 Fifth Avenue, Suite 2950 New York, NY 10111 (212) 314-0323 joseph.beck@morgankeegan.com	▪ 25+ years healthcare investment banking experience ▪ Morgan Keegan ▪ Shattuck Hammond Partners
	Richard Lorenti *Managing Director*	630 Fifth Avenue, Suite 2950 New York, NY 10111 (212) 314-0318 richard.lorenti@morgankeegan.com	▪ 25+ years healthcare investment banking experience ▪ Morgan Keegan ▪ Shattuck Hammond Partners
	Matthew Crosby *Senior Vice President*	50 N Front Street Memphis, TN 38103 (901) 531-3251 matthew.crosby@morgankeegan.com	▪ 13+ years investment banking experience ▪ Morgan Keegan ▪ Stephens Inc. ▪ First Tennessee Bank
	Peter Delaney *Associate Vice President*	630 Fifth Avenue, Suite 2950 New York, NY 10111 (212) 314-0363 peter.delaney@morgankeegan.com	▪ 6 years healthcare investment banking experience ▪ Morgan Keegan ▪ Shattuck Hammond Partners
	Zachary Singer *Analyst*	630 Fifth Avenue, Suite 2950 New York, NY 10111 (212) 314-0345 zachary.singer@morgankeegan.com	▪ 2 years healthcare investment banking experience ▪ Morgan Keegan
Equity Research – Acute Care Hospitals	**John W. Ransom** *Managing Director, Equity Research* *Director of Health Services Group*	880 Carillon Parkway Saint Petersburg, FL 33716 (727) 567-2593 john.ransom@raymondjames.com	▪ 25+ years healthcare services research ▪ First Union

HEALTHCARE FINANCE PROFESSIONALS

Joseph G. Beck
Managing Director
Co-Head Healthcare Finance Group
New York
(212) 314-0323
joseph.beck@morgankeegan.com

Mr. Beck has over 25 years of experience in investment banking in the healthcare services sector. He has held leadership roles in many of the industry's most innovative and influential transactions in the last decade, with broad experience in debt underwriting, private placements, mergers and acquisitions, and strategic advisory assignments for healthcare service companies and specialty not-for-profit corporations. His clients have included prominent hospitals and other healthcare and non-profit companies, including Lehigh Valley Health Network, Georgetown University, Visiting Nurse Service of New York, West Virginia United Health System, University of Miami, Association of American Medical Colleges, Rand Corporation and World Wildlife Fund.

Mr. Beck joined Raymond James in April 2012 following the Firm's acquisition of Morgan Keegan and joined Morgan Keegan in 2007 with the acquisition of Shattuck Hammond Partners. He was one of the founding members of Shattuck Hammond Partners LLC in 1998 and was also a Principal at Cain Brothers, Shattuck & Company. From 1985 to 1987, Mr. Beck served as Vice President at Chemical Bank, where he directed investment banking services for hospitals and other healthcare companies. Previously Mr. Beck was a Senior Credit Analyst at Moody's Investors Service, where he was responsible for hospital, letter of credit, and other structured finance ratings. He began his career working in New York State Government and the New York State Senate, holding senior staff positions in healthcare regulation and policy analysis. Mr. Beck graduated with a M.S. in Health Policy and Management from the School of Public Health at Harvard University and a B.A. from LeMoyne College.

Illustrative Transaction Experience

- Sale of Georgetown University Medical Center
- University of Miami's acquisition of Healthsouth facility
- Good Shepherd Group/University of Pennsylvania Health System Joint Venture
- Lehigh Valley Health Network Bond Financings and various M&A activities
- Various buy-side advisory for Visiting Nurse Service of New York
- Strategic Options Assessment for NY Archdiocese Health Care Businesses
- Hamot Health Foundation's sale of SpringHill and Forestview Facilities
- PennCARE Nursing Home Facilities debt placement agent
- Sale of Pathology Associates for Ameripath
- Howard Hughes Medical Foundation bond advisory
- Lehigh Valley Health Network bond remarketing
- NorthPenn Hospital sale to Universal Health Services
- Kaiser Family Foundation bond underwriting
- Private placement for Anchor Health Properties
- Financial Advisor on the sale of Lehigh Valley Health Network's DME business
- Financial advisor on Kaleida Health bond refinancings
- Good Shepherd Group bond advisory
- Financial Advisor for Covenant Health Systems on Bond Financing and Mergers/Acquisitions
- Rockford Health System's sale of Rockford Health Plans
- Strategic advisor with regard to Johns Hopkins Medicine's technology transfer opportunities
- Sale of Home Health Corporation of America
- Buy-side advisor to Private Healthcare Systems
- Financial Advisor to Greater Hazleton Health Alliance
- Sell-side advisor to IFIDA Health Care Group
- Sale of Orange Regional Medical Center's Crystal Run Pavilion MOB
- Buy-side advisor to Healthfirst
- Financial Advisor for RAND Corporation bond and derivatives restructurings

HEALTHCARE FINANCE PROFESSIONALS

Richard J. Lorenti
Managing Director
New York
(212) 314-0318
richard.lorenti@morgankeegan.com

Mr. Lorenti has served for over 25 years as an investment banker to a broad range of healthcare companies. His experience includes developing and implementing strategic and financial transactions primarily for privately held and not-for-profit healthcare companies. The types of transactions and services include mergers and acquisitions, capital raises, both publicly offered and privately placed, and strategic planning and options assessments.

Mr. Lorenti joined Raymond James in April 2012 following the Firm's acquisition of Morgan Keegan and joined Morgan Keegan in 2007 with the acquisition of Shattuck Hammond Partners, of which he was a co-founder. Prior to 1993, he was a Vice President at Cain Brothers, Shattuck & Company and at Dean Witter Reynolds. Mr. Lorenti was an analyst in the healthcare group at Standard & Poor's from 1979 to 1984. He earned his Masters in City and Regional Planning from the Harvard University Graduate School of Design and a B.S. in Architecture from The Catholic University of America.

Illustrative Transaction Experience

- Strategic capital plan and bond financings for Central Maine Health System
- Acquisition advisory for Consumers Union
- Bond financing restructuring for EMH Regional Health System (OH)
- Advisory for equity placement for publicly held HCIT company
- Advisory for acquisition of Laurelwood Hospital by Lake Hospital System (OH)
- Advisory for sale of Lehigh Valley Health System DME business
- Advisory for NYU Medical Center merger with Mt. Sinai Medical Center
- Advisory for sale of Mount Sinai Medical Center (OH)
- Advisory for small privately held Physician billing service
- Advisory for formation of and equity placements for Prime Therapeutics LLC
- Advisory for sale of Richmond Heights General Hospital (OH)
- Strategic capital plan and bond financing for ViaHealth/Rochester (NY) General Hospital
- Advisory for sale of two privately held Surgery center businesses
- Bond financing for Village Care of New York
- Advisory for Visiting Nurse Service of New York's acquisition of various home health businesses

HEALTHCARE FINANCE PROFESSIONALS

Matthew M. Crosby
Senior Vice President
Memphis, TN
(901) 531-3251
matthew.crosby@morgankeegan.com

Mr. Crosby has been in investment banking for over 13 years advising clients in a broad range of industries, including financial institutions, technology, security and defense companies and most recently healthcare organizations. He has advised senior management and boards of directors on mergers and acquisitions, public and private debt and equity capital raises and strategic options assessments. His primary focus is advising not-for-profit hospitals and healthcare systems on merger and acquisition, joint venture and affiliation transactions.

Mr. Crosby joined Raymond James in April 2012 following its acquisition of Morgan Keegan. Prior to Raymond James, Mr. Crosby served for nine years helping build Morgan Keegan's Security and Defense investment banking practice. Before joining Morgan Keegan's investment banking group, Mr. Crosby launched the Total Returns research group within Morgan Keegan's Fixed Income Research practice. Mr. Crosby began his career at First Tennessee Bank in its Commercial Real Estate Lending group before joining Stephens Inc.'s investment banking practice. He received his M.B.A. from the Tuck School of Business at Dartmouth and a B.B.A. from Millsaps College.

Illustrative Transaction Experience

- Strategic Review and Analysis for Skilled Nursing Facility Owner/Operator
- Advisor to GPO for Valuation considerations regarding an IPO
- Sell-side advisor to DRI Corporation, $80M intelligent transportation systems provider, for 363 sale of assets Sell-side advisor to Alarm Capital Alliance, a $180M alarm monitoring company
- Sell-side advisor to DTT Surveillance, a $93M full-service, digital surveillance system provider
- Sell-side advisor to EQT in the sale of Securitas Direct, a $3.4B Swedish alarm monitoring provider
- Sell-side advisor and fairness opinion for March Networks, a $100M Canadian provider of IP video surveillance solutions to Shenzen Infinova, a $500M Chinese IP video surveillance solution provider
- Sell-side advisor to 3eTI, $30M provider of high-security wireless networking solutions, to Ultra Electronics, a $1B, UK-based defense electronics company
- Sell-side advisor to Reveal Imaging Technologies, Inc., a $250M explosives screening and detection provider to SAIC, Inc.
- Sell-side advisor to Syson Justice Systems, a $30M provider of offender management systems and services, to Sverica International
- Buy-side advisor to GTCR for purchase of Protection One, an $850B alarm monitoring company
- Sell-side advisor and fairness opinion for Quixote Corp., a $105M provider of highway and transportation safety products to Trinity Industries Inc.
- Sell-side advisor and fairness opinion for American Bank Note Holographics, a $138M provider of covert and overt security solutions for credit cards, IDs paper certificates, etc. to JDS Uniphase

HEALTHCARE FINANCE PROFESSIONALS

Peter H. Delaney
Associate Vice President
New York
(212) 314-0363
peter.delaney@morgankeegan.com

Mr. Delaney joined Raymond James in April 2012 following the Firm's acquisition of Morgan Keegan and joined Morgan Keegan in 2007. He provides transaction and analytical support to senior bankers on a variety of engagements, including mergers and acquisitions, financings and strategic advisory services. Mr. Delaney has worked with a variety of clients including physician practice management companies, post-acute care operators, senior living companies, multi-hospital health systems and single community hospitals. He received a B.A. in Economics from Vanderbilt University, where he graduated *magna cum laude*.

Illustrative Transaction Experience

- Recapitalization of Management Services Company of North American Partners in Anesthesia
- Recapitalization of Leading Regional Anesthesia Practice
- Sale of operations of PennMed Consultants, servicing 1,600 beds in 18 skilled nursing facilities
- Sale of Archdiocese of New York's Membership Interest in New York Medical College
- Sale of Siena Health Ventures, LLC to Silver Oak Services Partners
- Strategic review of proposed physician surgical hospital in AR
- Strategic Advisory for Liberty HealthCare System
- Strategic Options Assessment for St. Barnabas Hospital
- Strategic Options Assessment for Valley Health System
- Strategic Options Assessment for Saint Clare's Health System
- Private Placement for Norwalk Hospital
- Bond Financing for The Good Shepherd Group
- Bond Financing for Orange Regional Medical Center
- Bond Financing for Washington County Health System
- Bond Financing for Cooper Health System
- Swap Advisory Services for Lehigh Valley Health System

Zachary H. Singer
Analyst
New York
(212) 314-0345
zachary.singer@morgankeegan.com

Mr. Singer joined Raymond James in April 2012 following the Firm's acquisition of Morgan Keegan and provides transaction and analytical support to senior bankers on a variety of engagements, including, mergers and acquisitions, real estate transactions, financings and strategic advisory services.

Prior to joining the firm, Mr. Singer was a summer analyst in the firm's Chicago office. He earned a B.S. in Economics with a concentration in finance from the Wharton School of Business at the University of Pennsylvania, where he graduated *summa cum laude*.

SECTION 3

Diligence Needs

PRELIMINARY DATA REQUEST LIST

Utilization Information (broken out by BHHCG, Bristol Hospital and Ingraham Manor, where applicable)

1. Utilization data for each of the last three fiscal years and year-to-date, as follows:
   - General Utilization Statistics and Operating Data/Dash Board Indicators (as reported in previous continuing disclosure filings).
   - Number of operating and licensed beds by major service (medical/surgical, obstetrics, ICU, CCU, psych, etc.) and overall.
   - Inpatient discharges and outpatient visits by major service and overall (newborns separately, if possible).
2. Current fiscal year budgeted utilization/operating statistics.

Financial Information (broken out by BHHCG, Bristol Hospital and Ingraham Manor, where applicable)

1. Final/Draft Audited Financial Statements for the year ended September 30, 2012.
2. Draft Interim December 31, 2012 Financials (or latest available with prior year comparable period).
3. FY 2013 Budget and any future projections.
4. Detailed revenue and expense information for the last three fiscal years.
   - Gross and net revenue for inpatient and outpatient services.
   - Payor mix as a % of inpatient/outpatient revenues (gross and net, if possible).
   - Operating Expenses:
     - Salaries and wages
     - Professional fees
     - Insurance
     - Supplies
     - Repairs, maintenance, utilities
     - Benefits
     - Contract services
     - Leases, rentals
     - Bad debts
     - Other operating expenses
5. All FTEs, by department.
6. Description of any non-recurring or special accounting items not specifically disclosed in the financial statements.
7. Operating and capital budgets for the current and next fiscal years, including major budget assumptions.
8. Summary of operating and/or capital leases (lessor, rate, annual payments, term, etc.).
9. Documentation relating to outstanding financial instrument obligations (i.e. Mortgages, Direct Placements, Interest Rate Swaps, etc.).
10. Summary of major liabilities, especially pension plans and their funding status.
11. Physician Alignment Strategy (including projected costs of physician alignment strategy and associated potential future revenue).

PRELIMINARY DATA REQUEST LIST (CONT'D)

Payor Information
1. Listing of major managed care contracts, including lives covered, pricing structure/reimbursement procedures, and expiration date.
2. Indicate whether the hospital receives state indigent payments or disproportionate share, or any other special funding (i.e., EMR, other government payments), payments as part of the Medicare or Medicaid programs. If so, provide payments received for the last three years and payments expected for any future periods.
General Business
1. Detailed description of business (including, but not limited to, overview and background, history, governance, affiliated entities, facilities/services, medical staff, service are and market environment, etc.).
Transaction Specific
1. Agreement (and related Exhibits and Schedules).
2. Management Agreement, if applicable.
3. CON Application, if applicable.
4. Copies of transaction proposals from other parties and any Board summaries of the proposals.
5. Summary of Transaction Process.
6. Board packages for the last three years.

SECTION 4

Process Timeline

OVERVIEW OF FAIRNESS OPINION PROCESS

As an independent advisor to BHHCG and the Board, Raymond James | Morgan Keegan would provide the services described below.

- In giving the Fairness Opinion, we will, among other things:
  - Review BHHCG's audited financial statements, internal financial and operating information, including any projections prepared by BHHCG or its advisors;
  - Review any valuation materials prepared by any advisors to BHHCG in connection with the transaction;
  - Discuss the business, financial condition and prospects of BHHCG;
  - Review the financial terms of the transaction;
  - Review the publicly available financial terms of relevant similar transactions;
  - Review publicly available information relating to certain companies we deem appropriate in analyzing the valuation of BHHCG; and
  - Perform other analyses and examinations and consider such other information, financial studies, analysis and investigations and financial, economic and market data as we believe relevant.
- We have outlined on the next page a specific timeline of the process based on BHHCG's tight time frame.

REPRESENTATIVE PROCESS TIMELINE

Raymond James | Morgan Keegan is regularly engaged in fairness opinion and valuations of business on tight time frames. We are highly confident we will be able to produce a fully detailed report by January 16, 2013.

- Timely receipt of requested materials and availability of BHHCG's Board and Management will be critical given the compact timing.

Review of Business and Proposed Agreement	Valuation	Formulate Opinion	Deliver Final Report
1 week	1 week		
5 – 7 Days	4 – 6 Days	1 – 3 Days	1 – 2 Days
• Discuss the business, operations, financial performance, strategic plans, regional market conditions and future trends, and prospects of BHHCG with certain officers of BHHCG and Vanguard; • Review the Agreement and the related Exhibits and Schedules; • Review additional Transaction Documents; • Review the historical financial and operating information for BHHCG, as provided by management; • Review operating budget and strategic initiatives; • Review projected capital expenditure schedules; • Assess of market environment.	• Review publicly available financial, operating and descriptive information regarding relevant hospital acquisitions; • Review publicly available financial, operating and descriptive information on certain publicly-traded hospital companies; • Review projected financials for BHHCG (if applicable); • Review the financial terms of the Transaction; • Consider additional aspects about BHHCG's business model that we believe are relevant to valuation.	• Review the legality of the proposed transaction (CON approval, CT state laws, etc.); • Consider external factors (current conditions, pension issues, reimbursement factors, state/federal budget constraints, etc.); • Perform such other financial studies and analyses and considered such other information we deemed appropriate.	• Share draft of report with BHHCG; • Draft and Deliver the final report; • Participate in any discussions as necessary.

SECTION 5

Outline of Other Logistics & Coordination

OUTLINE OF OTHER LOGISTICS AND COORDINATION

We are prepared to commence the engagement immediately.

- As described earlier, given the tight time frame, we will require timely receipt of materials requested and access to Management and the Board of BHHCG.
- Most Members of our team, including Joe and Richard, are based out of New York and can be available to travel out to Bristol on relatively short notice.

SECTION 6

Compensation Structure

RAYMOND JAMES | MORGAN KEEGAN PROPOSED COMPENSATION STRUCTURE

We propose the compensation structure outlined below.

- A signing retainer of
- Upon delivery of the final report, a fee of
- Reimbursement of reasonable out-of-pocket expenses.
- Customary indemnification provisions.

SECTION 7

Disclosure of Any Conflicts of Interest

CONFLICTS OF INTEREST

Raymond James | Morgan Keegan is not aware of any conflicts of interest in connection with this engagement.

- There are no issues with respect of BHHCG's exclusivity requirement outlined in the RFP.
- Our professional's reputation spanning more than 20 years experience along with Raymond James quality brand name will lend significant credibility to the Fairness Opinion.

RAYMOND JAMES®

Morgan Keegan

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

December 15, 2012

Board of Trustees of the Greater Bristol Hospital and Health Care Group, Inc.
P.O. Box 977
Bristol, Connecticut 06011-0977

Attention: Mr. George Eighmy, CPA, FHFMA
Vice President of Finance and CFO

Re: Fair Market Valuation Engagement for Greater Bristol Hospital and Health Care Group.

This letter serves as our proposal to provide the Board of Directors of Greater Bristol and Health Care Group ("Board" or "BHHCG") a Fairness Evaluation in conjunction with its announced sale to Vanguard Health Systems (the "Transaction").

PURPOSE AND BACKGROUND

We understand that the purpose of our analysis will be to provide the Board a fairness evaluation of the Transaction in order for the Board to fulfill its fiduciary duties and obligations under the State of Connecticut's General Statute C.G.S. 19a-486(c)(5) et seq. ("Conversion Statute").

SCOPE

In determining whether the consideration is fair from a financial point of view we will specifically address the following additional valuations or considerations required under the Statute:

- Assess the "Fair Market Value" of the assets to be transferred by BHHCG
- Assess the intangible value to the Bristol community of maintaining its overall Mission
- Conduct analysis to consider the valuations of for-profit-versus not-for-profit organizations and academic hospital systems versus community hospital

In conducting these assessments the following considerations will be made:

- Review the Transaction terms associated with the Conversion
- Conduct a site visit to the Hospital to accurately describe and assess the condition of the assets to be transferred

- Review the historical and earning potential of the operating assets that BHHCG intends to transfer
- Review the plans, budgets, and financial projections associated with the hospital under its new ownership structure
- Consider the overall market potential of BHHCG
- Review and analyze other pertinent and necessary information necessary to arrive at our final opinions

Fair Market Value for the purposes of this analysis will be defined as follows:

> 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.

PRINCIPLE VALUATION FIRM OVERVIEW, RELEVANT EXPERIENCE, AND TEAM MEMBERS

In 2007, Timothy Baker and David Felsenthal combined their 75 years of healthcare appraisal experience to form Principle Valuation, a firm dedicated to service the specialized needs of the healthcare community. In 2009, Patrick Simers joined as a Principal in the firm and added to the strength of the overall hospital valuation core with more than 25 years in the appraisal of Healthcare properties. All of the Principals of Principle Valuation ("PV"), have served as Presidents and Vice Presidents of many of the major healthcare valuation and healthcare consulting providers including Huron Consulting, American Appraisal, CBIZ, and Valuation Counselors, a valuation firm that Mr. Felsenthal had previously founded which became the premier healthcare valuation firm in the industry. From its inception the staff of Principle has continued to expand and we now have more than seventeen professional employees dedicated to the valuation of healthcare related entities.

Our business is generally segmented into three primary sectors; Hospital and Healthcare Enterprise Related Services, Healthcare Advisory Services; and Senior Housing Related Services.

In the Hospital and Healthcare Related services group the primary emphasis is to prepare valuations to meet the regulatory guidelines associated with hospital transactions including Stark compliance, State Regulatory Requirements and Purchase Accounting. Valuations conducted in this sector generally include the valuation of hospitals and hospital systems, medical practices, joint ventures valuations, service agreements and other types of healthcare business arrangements. Another major focus of this group is the valuation of tangible and intangible assets associated with purchase accounting for Acute and Specialty Hospitals. Professionals in this group have real estate, medical equipment, and business enterprise expertise.

The Healthcare Advisory Services group is primarily responsible for the preparation of cost segregation studies, facility live analysis, and asset inventory and reconciliation reports. This group's personnel consists of staff members with engineering and tax expertise that assist our clients in reducing their overall tax liability and developing accurate property records that help our clients increase their overall bond ratings. Our Senior Housing Group focuses on the service needs of the senior housing industry. This group prepares market studies and valuations of nursing homes and assisted living residences. Their work is generally presented for financing and utilized to obtain financing in the HUD 232 program. Professionals in this group include real estate professionals who have detailed knowledge of the regulatory rules and reimbursement policies that dictate the nursing care industry.

Particularly relevant assignments include fairness reviews and appraisals presented to comply with the Attorney General requirements in Connecticut, Georgia, Mississippi, Louisiana, Florida, Ohio, and New Jersey. Direct hospital transfer assessments included Greater Waterbury Health System and St. Mary's Health System in Waterbury Connecticut, Banks-Jackson-Commerce Hospital in Georgia; Baptist Memorial Hospital – North Mississippi in Mississippi; Ville Platte Medical Center and West Carroll Memorial Hospital in Louisiana; South Shore Hospital in Miami, Florida; and UPMC in Pittsburg, Ohio. We also recently assessed a hospital management agreement for Meadowlands Hospital Medical Center in New Jersey.

The primary parties that will be active in this engagement include Tim Baker, Patrick Simers, and Mary Jo Duffy. As demonstrated by their Qualifications, each member of the team has more than 25 years in the valuation of healthcare enterprises and includes individuals with General Appraiser State Certifications, and CPA's. These qualifications are included in the Addenda of this proposal.

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 BHHCG 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 BHHCG Hospital operations
- A current Balance Sheet of the Organization and an explanation of which assets are anticipated to transfer
- A copy of the current fixed asset ledger of the Hospital and its associated entities 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 Cain Brother's prepared in making its overall recommendations to the Board
- The Current Plans, Budgets, and Forecasted Financials for the operations under new management
- A copy of the Purchase Agreement between BHHCG and Vanguard
- A copy of the proposed Operating Agreement between BHHCG and Vanguard
- A Contact at Vanguard that we can discuss their overall business operations, history, capital resources, financials, etc.
- The Management and Organizational Structure associated with the Purchase
- Any Demographic, Market Research, or Competitive Surveys that were conducted to support the overall merger
- A brief write-up of the subject's current ownership and operational history
- Any other data that you feel is necessary that enhances our understanding of the Transaction

PROCESS TIMELINE, LOGISTICS, AND COORDINATION

We would anticipate the following general time line which would lead to an overall engagement completion by January 16, 2013.

1st Week (12-21-13)	Award of contract and receipt of data requested
2nd Week (12-28-2013)	Review of Data forward and coordinate site visit needs
3rd Week (1-4-13)	In House Analysis and Site Visit January 2-4
4th Week (1-11-13)	**Presentation of Draft Findings and commencement of Fairness Opinion Documentation**
5th Week (1-16-13)	Development of Draft Fairness Opinion and AG Schedules
6th Week (1-23-2013)	Presentation and Development of Final Fairness Opinion and AG Schedules.

Though we believe that meeting the Draft deadline is certainly achievable, the time line detailed above, with the current holiday schedule ahead and the diligence effort required is somewhat time sensitive and that delays in the receipt of data or the review of preliminary schedules provided may alter the delivery schedule. 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.

CONFIRMATION OF ABSENCE OF ANY CONFLICTS OF INTEREST

Neither Principle Valuation nor its staff members have any known conflict of interest with the parties to this Transaction or to the Transaction itself. We further agree not to perform or be contracted for any investment banking services for Vanguard Health Systems or any patient care organization operating within 20 miles of BHHCG for a period commencing at the time of the engagement until the delivery of the work product.

COMPENSATION STRUCTURE

Our fee for this engagement will be inclusive of all expenses. We ask that a retainer of be issued upon acceptance of this letter. We will subsequently bill upon presentation of our initial findings and draft report with the final balance due upon completion of the engagement. We anticipate all payments to be current prior to issuing our final report. Our final invoice will accompany our final report; or if no final report is desired, upon your indication that no final report is required. Our fee is in no way contingent upon the outcome of our conclusions. This 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 Greater Bristol Hospital and Health Care Group, Inc. will mutually revise the fee to reflect those changes in services.

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, testimony and appearance in front of any tribunal, agency or other body subsequent payment will be required and 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.

BHHCG 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 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 BHHCG 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

AUTHORIZATION

CLIENT: Greater Bristol Hospital and Health Care Group, Inc.

SIGNATURE(S): _____

NAME (PRINT OR TYPE): _____

TITLE: _____

DATE: _____

PHONE: _____

PROFESSIONAL QUALIFICATIONS

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 Arizona, Indiana, Maryland, New Jersey, and New York

TESTIMONY

- Testified as expert witness in California, Colorado, Connecticut, New Hampshire, New Jersey and Pennsylvania

PROFESSIONAL QUALIFICATIONS

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 spearheaded 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

PROFESSIONAL QUALIFICATIONS

MARY JO DUFFY, CPA

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.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 11: PRINCIPLE VALUATION'S FAIRNESS OPINION

PV14.1398

FAIRNESS OPINION

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.

SUBMITTED TO:
BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
ATTENTION: MR. GEORGE EIGHMY, CPA, FHFMA
VICE PRESIDENT OF FINANCE AND CFO
P.O. BOX 977
BRISTOL, CONNECTICUT 06011-0977

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

September 10, 2014

Board of Trustees of the Bristol Hospital and Health Care Group, Inc.
P.O. Box 977
Bristol, Connecticut 06011-0977

Attention: Mr. George Eighmy, CPA, FHFMA
Vice President of Finance and CFO

Re: Fairness Opinion for Potential Sale of Bristol Hospital and Health Care Group, Inc. to Vanguard Health Systems, Inc.

Ladies and Gentlemen:

Pursuant to the Asset Purchase Agreement, (dated November 20, 2013 and updated as of July 1, 2014), Bristol Hospital and Health Care Group, Inc. and its subsidiaries ("Bristol") will be sold to VHS Bristol Health System, LLC ("VHS") (the "Transaction"). VHS Bristol Health System is owned by VHS Connecticut, Inc. with Tenet Healthcare Corporation ("Tenet Healthcare") as an indirect owner. Pursuant to the proposed Transaction the Board of Bristol 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 30, 2014 giving consideration to historical data available as of March 31, 2014 and subsequent financial data provided to us by Bristol 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 Bristol's Assets (inclusive of $7,000,000 of net working capital) for $50,000,000;
- VHS will assume pension liabilities of Bristol relating to its frozen defined benefit pension plan and any accrued post-retirement or other retirement obligation described on Schedule 2.03 of the Agreement. These total $28,035,427 as of March 31, 2014 and will be subtracted from the proceeds to Bristol at closing. 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 $45,000,000 in capital projects, including routine and non-routine capital expenditures over a six 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 Bristol with the proposed sales terms. In arriving at the opinion set forth below, we have among other things:

- Visited the Bristol Hospital Site to describe and assess the overall condition of the physical assets and improvements (the site visit was conducted in October 2013 and a brief inspection was performed in July 2014. We have relied upon representations that there have been no significant changes have occurred at the site);
- Been provided and reviewed certain available business and financial information relating to Bristol that was provided by Bristol'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 March 31, 2014;
- Been provided and relied upon the operating budget for fiscal 2014 prepared by Bristol management as a Stand-Alone organization if the transaction does not occur;
- Reviewed the Draft Asset Purchase Agreement by and between Bristol Hospital and Health Care Group, Inc. and VHS Bristol Health System, LLC dated November 20, 2013 and updated as of July 1, 2014;
- Reviewed minutes of the Board of Directors of Bristol Hospital and Health Care Group for the period June 8, 2012 through August 6, 2014; reviewed Partnership Committee minutes for the period August 15, 2011 through November 1, 2013; reviewed Strategic Planning Committee minutes for December 12, 2013, January 13, 2014, January 22, 2014, and March 31, 2014; reviewed the joint Strategic Planning Committee and Partnership Committee minutes for December 2, 2013, May 30, 2014, June 19, 2014, and July 31, 2014;
- Reviewed the proposed Board of Trustees Bylaws of Bristol Hospital dated November 13, 2013;
- Reviewed the proposed Limited Liability Company Agreement of VHS Bristol Health System, LLC dated November 13, 2013;

- Reviewed and relied upon certain information contained in the Bristol Hospital Strategic Planning presentation dated February 14, 2013 prepared by The Chartis Group;
- Reviewed the preliminary strategic capital spending plan prepared as of April 16, 2013; Reviewed the capital projects schedule for 2014;
- Considered the criteria set forth in Conversion Statute;
- Interviewed members of Bristol'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 Bristol under any state or federal laws relating to bankruptcy, insolvency, or similar matters.

We have made a physical visit to the Bristol 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 October 2013, with a brief visit in July 2014, and upon representations of management we believe that the overall condition of the assets are in a similar condition as when initially inspected, wear and tear excepted. With respect to the financial forecast provided to or discussed with us by representatives of Bristol, we have assumed that they have been reasonably prepared and reflect the best currently available estimates and judgment of Bristol as to the expected future financial performance of Bristol. We have also assumed that the final form of the Asset Purchase Agreement will be substantially similar to the draft reviewed by us dated July 1, 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 Bristol's assets or the financial condition or operations of Bristol or the expected future financial performance of Bristol. 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 Bristol to solicit, nor have we solicited, third-party indications of interest for the acquisition of Bristol'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. Bristol 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 Bristol, 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. Bristol 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 Partnership Committee, and speaking with Bristol'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 Bristol, 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 30, 2014, the Consideration set forth in the Transaction is fair from a financial point of view to Bristol.

(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 Bristol'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 Bristol 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) A sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after

the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor;

Based on the materials and interviews referenced in this letter and our review of the proposed Transaction, (a) the fair market value of Bristol's assets will be sold and (b) the fair market value of Bristol's assets (after payment of liabilities) is being transferred to an independent community foundation to be selected by the superior court whose directors are not affiliated through corporate structure, governance, or membership with either Bristol or VHS. Bristol has indicated to us that the restricted assets will be used for purposes consistent with the intent of their donors. Principle Valuation has conducted no investigation into the source, limitations, or value of the restricted use assets.

(9) 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. Bristol 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, Bristol submitted its application.

Respectfully submitted,

PRINCIPLE VALUATION, LLC

PV14.1398

E X H I B I T S

A S S E T P U R C H A S E A G R E E M E N T (D R A F T)

~~*VHS DRAFT 11/20/2013*~~*F&L COMMENTS JULY 1, 2014*

ASSET PURCHASE AGREEMENT

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

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of ~~Seller,~~ Bristol Hospital, Inc. (the "**Hospital**"), Bristol Hospital Multispecialty Group, Inc. ("**BHMSG**"), Bristol Hospital EMS, LLC ("**EMS**"), and Bristol Health Care, Inc., including its subsidiary Ingraham Manor (the foregoing entities and the businesses operated by ~~the foregoing~~these entities, including the Hospital, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Bristol MSO, LLC (50%), Medworks, LLC (50%), Connecticut Occupational Medicine Partners, LLC (33%), MedConn Collection Agency, LLC (20%), Total Laundry Cooperative, LLC (9%), Central Connecticut Endoscopy Center, LLC (6.5%), and Health Connecticut, LLC (5.4%) (the foregoing entities are collectively referred to herein as the "**Joint Ventures**");

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

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

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

AGREEMENT:

1. DEFINITIONS AND REFERENCES

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

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program

receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise; *provided* that no stockholder of Tenet Healthcare shall be considered an Affiliate for the purposes of this Agreement;

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

(4) **Affirmative Election** is defined in Section 5.22(a);

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

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

(7) **Assumed Liabilities** means (i) the current liabilities included in Net Working Capital, but only to the extent accrued on the Closing Balance Sheets, (ii) all obligations of Seller arising under the Assumed Contracts with respect to periods (or portions thereof) following the Closing Date, (iii) all participating provider agreements and provider numbers with third party payors, including contracts and provider numbers of Government Payment Programs, to the extent the same are assignable to Buyer, (iv) all paid time off accruals of the Hired Employees (other than Extended Illness Bank Obligations) and estimated Taxes thereon, (v) the Extended Illness Bank Obligations, (vi) Permitted Encumbrances, (vii) any pension liability of Seller relating to its frozen defined benefit pension plan, (viii) any accrued post-retirement or other retirement obligation described on Schedule 2.03 and (ix) the other liabilities and obligations agreed to be assumed by Buyer, if any, described on Schedule 2.03;

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

(9) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Subsidiaries for the years ended September 30, ~~2010,~~ 2011, ~~and~~ 2012, and 2013, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes

thereto and the report thereon of Saslow Lufkin & Buggy, LLP, independent certified public accountants;

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

(11) **Buyer Deductible** is defined in Section 9.04(a);

(12) **Buyer's Indemnified Persons** means Buyer, VHS CT, Tenet Healthcare, ~~Buyer's members and Subsidiaries, Tenet Healthcare's stockholders, Affiliates,~~Yale-New Haven Health System Corporation, and their successors and assigns, ~~and~~together with their respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents and representatives;

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

(14) **CHEFA Bonds** means the tax-exempt bonds issued to Seller through the State of Connecticut Health and Educational Facilities Authority Revenue Bonds, Bristol Hospital Issue, Series B, with an issue date of January 8, 2002;

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

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

(17) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the close of business on the Closing Date, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

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

(19) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing, including~~, without limitation,~~ the Local Board Bylaws and the Operating Agreement;

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

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

(22) **Community Foundation** means that certain community foundation designated by Seller in its sole discretion and approved by the Attorney General,

which community foundation shall not be affiliated with Seller, shall be organized and operated exclusively for charitable purposes, exempt from federal tax under section 501(c)(3) of the Code, and shall be publicly supported in accordance with section 170(b)(1)(A)(vi) of the Code (as modified by the accompanying Treasury Regulations);

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

(24) **Controlled Group** means with respect to Seller, a group consisting of each trade or business (whether or not incorporated) that, together with such Seller, would be deemed a "*single employer*" within the meaning of section 4001(a)(14) of ERISA;

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

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

(27) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with generally accepted accounting principles consistently applied;

(28) **Election Period** is defined in Section 5.22(a);

(29) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained or required to be sponsored or maintained by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section

3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

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

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

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

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

(34) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

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

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

(37) **Essential Services** means those ~~Hospital~~hospital services described on Schedule 5.18;

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

(39) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing, including any line of credit to which Seller is a party, the CHEFA Bonds, any other indebtedness of Seller, any interest accrued as of the Closing Date on indebtedness of Seller, any settlements due as of Closing to third party payors, and all medical malpractice, general liability and workers' compensation claims that relate to any pre-Closing period;

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

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

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

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

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

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

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

(46) ~~(47)~~ **Immaterial Contract** means any Contract to which Seller or any of the Hospital Businesses is a party that requires either the payment by Seller or any of the Hospital Businesses of $25,000 or less or the provision of goods or the performance of services by Seller or any of the Hospital Businesses having a value of $25,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Hospital Business without cause upon notice of ninety (90) days or less, the date on which the

Contract would terminate if Seller or the respective Hospital Business were to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Hospital Business without cause upon notice of ninety (90) days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Sections 3.18(a) through 3.18(n);

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

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

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

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

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

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

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

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

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

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

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

(58) ~~(59)~~ **Local Board** means the board of trustees for the Hospital, established pursuant to Section 5.17 below and the Local Board Bylaws;

(59) ~~(60)~~ **Local Board Bylaws** means the bylaws or other governing document of the Hospital implemented as of the Closing Date and setting forth the rights and obligations of the Local Board, in substantially the form of Exhibit A attached hereto;

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

(61) ~~(62)~~ **Material Adverse Change** means a material adverse change, individually or in the aggregate, on the business, assets, liabilities, financial condition, or results of operations of Seller and the Hospital Businesses taken as a whole, but excluding the effect of (i) matters described in the Schedules, (ii) changes in the economy of the United States in general or general economic or industry conditions generally applicable to hospitals or health care facilities within the United States or the State of Connecticut so long as such conditions do not disproportionately affect Seller and the Hospital Businesses, (iii) the announcement of the execution of this Agreement or the transactions contemplated hereby or the performance of any obligations hereunder, (iv) accounting changes required by generally accepted accounting principles, (v) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut, including changes or proposed changes to any state or federal law, reimbursements rates or policies of Governmental ~~Entities~~Authorities, if such change does not disproportionately affect Seller or the Hospital Businesses, or (vi) effects that are cured, or susceptible to cure without unreasonable effort, by Seller; provided that

if the normalized earnings before interest, depreciation and amortization of the Hospital Businesses on a consolidated basis for the trailing 12-month period through the date of the most recent interim financial statements provided to Buyer pursuant to Section 5.04(b) (the "**Trailing EBITDA**") is not less than 80% of the normalized Trailing EBITDA for the preceding 12-month period, then a Material Adverse Change will not be deemed to have occurred (it being understood, however, that any facts, events, changes or developments causing or contributing to the failure of Seller's Trailing EBITDA to equal or exceed the normalized Trailing EBITDA for the preceding 12-month period may be taken into account in determining whether a Material Adverse Change has occurred).

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

(63) ~~(64)~~ **Medical Waste** means any waste generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings, and (xi) any substance, pollutant, material or contaminant listed or regulated under the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.* or under the Medical Waste Law of any State;

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

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

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

(67) ~~(68)~~ **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Hospital Businesses acquired by Buyer, including useable inventory and supplies, Accounts Receivable, other receivables, useable prepaid expenses and deposits (including security deposits made by Seller pursuant to Assumed Contracts), exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Unaudited Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time but exclude Extended Illness Bank Obligations);

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

(69) ~~(70)~~ **Offer** means a *bona fide* written offer pursuant to which a Person that is not an Affiliate of Buyer (other than Yale New-Haven Health Services Corporation ("Yale") or its Affiliates, provided that Yale or such Affiliate assumes the obligations of Buyer hereunder) would purchase, directly or indirectly, all or substantially all of the equity interests of the Hospital Businesses, or Assets of the Hospital Businesses that, in the aggregate, produce at least twenty-five percent (25%) of the total revenue of the Hospital Businesses, for the consideration and upon the other terms and conditions set forth in such offer. For the avoidance of doubt, ~~any sale~~(a) any corporate-level transactions involving Tenet Healthcare's stock or securities, including macro-level mergers, recapitalizations or reorganizations, (b) any sale of some or all of the Hospital Businesses (or Assets thereof) required by a Governmental Authority, other than such a sale to which the right of first refusal under Section 5.22(a) applies, and (c) any sale, merger or other transaction by Buyer or its Affiliates ~~where other health care facilities of Buyer's Affiliates are being sold as part of the transaction~~that does not relate solely or principally to the Hospital Businesses (or Assets related thereto) shall not be considered an Offer for purposes of this Agreement;

(70) ~~(71)~~ **Operating Agreement** means the Operating Agreement of Buyer, in substantially the form of Exhibit B attached hereto;

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

(72) ~~(73)~~ **PBGC** means the Pension Benefit Guaranty Corporation;

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

(74) ~~(75)~~ **Permitted Encumbrances** means the Permitted Personal Property Encumbrances and the Permitted Real Property Encumbrances;

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

(76) ~~(77)~~ **Permitted Real Property Encumbrances** means (a) encumbrances for Taxes, assessments and other charges of Governmental Authorities not yet due and payable or being contested in good faith, (b) statutory liens incurred in the ordinary course of business for amounts not yet due and payable and not in connection with any Seller default, (c) rights of tenants as tenants only, disclosed in the rent roll attached as Schedule 3.12(g); *provided*, that none of the foregoing do or will, individually or in the aggregate, materially impair the value or continued use and operation of the property to which they relate in the Hospital Businesses as presently conducted, and (d) those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

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

(78) ~~(79)~~ **Principal Credit Agreement** means the Amended and Restated Credit Agreement, dated as of October 19, 2010 (as amended, modified, restated and supplemented from time to time), among Tenet Healthcare, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the other parties thereto, providing for the making of loans to, and the issuance of, and participation in, letters of credit for the account of the borrower thereunder, and any credit agreement or credit facility that replaces such Amended and Restated Credit Agreement;

(79) ~~(80)~~ **Prior Seller Plan** is defined in Section 3.22(b);

(80) ~~(81)~~ **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(81) ~~(82)~~ **Prohibited Transaction** is defined in Section 5.10;

(82) ~~(83)~~ **Purchase Price** is defined in Section 2.05(a);

(83) ~~(84)~~ **Purchase Price Adjustment** is defined in Section 2.05(e);

(84) ~~(85)~~ **Reportable Event** is defined in section 4043 of ERISA;

(85) ~~(86)~~ **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(86) ~~(87)~~ **Seller** ~~is defined in the preamble;~~means Bristol Hospital and Health Care Group, Inc., and includes as well all the Hospital Businesses unless the context clearly indicates otherwise.

(87) ~~(88)~~ **Seller Deductible** is defined in Section 9.02(a);

(88) ~~(89)~~ **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Subsidiaries, Affiliates, successors and assigns, and their respective stockholders, members, partners, Subsidiaries, Affiliates, directors, trustees, officers, employees, agents and representatives;

(89) ~~(90)~~ **Strategic Business Plan** means the five-year strategic and business plan and associated budget collaboratively developed by Seller and Buyer that identifies the needs of Bristol, Connecticut and its surrounding communities with respect to institutional, physician, and ambulatory care services and the resources necessary to attain such needs, as the same may be amended from time to time in accordance with Section 5.30;

(90) ~~(91)~~ **Subject Interest** is defined in Section 5.22(a);

(91) ~~(92)~~ **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with generally accepted accounting principles to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(92) ~~(93)~~ **Target Net Working Capital** means $[7,000,000];

(93) ~~(94)~~ **Tax** means any income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(94) ~~(95)~~ **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code section 501(c)(3) organization required by a federal of state Governmental Authority, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(95) ~~(96)~~ **Tenant Leases** is defined in Section 3.12(i);

(96) ~~(97)~~ **Third Party Claim** is defined in Section 9.05(a)(i);

(97) ~~(98)~~ **Title Representations** means the representations and warranties of Seller set forth in (i) the last sentence of Section 3.11 and (ii) the last sentence of Section 3.12(a);

(98) ~~(99)~~ **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*;

(99) ~~(100)~~ **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Subsidiaries as of [_____], 2014, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the [_____]-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b); and

(100) ~~(101)~~ **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq*.

1.02. Certain References. As used in this Agreement:

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships, joint ventures and limited liability companies;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Bristol, Connecticut time;

(i) references to "*Seller's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(a), after due inquiry by Seller of such Persons;

(j) references to "*Buyer's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(b), after due inquiry by Buyer of such Persons;

(k) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(l) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment ~~at~~of the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned or leased by Seller or used in the conduct of the Hospital Businesses; *provided* that any such leased personal property shall be described on Schedule 2.01(b);

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical/administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

(f) the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), the leases relating to the leased personal property listed or described on Schedule 2.01(b), and all Immaterial Contracts not listed or described on Schedule 2.02(j) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and the Information Systems;

(i) all property of Seller, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) the Investment interests in the Joint Ventures, including all transferable rights relating thereto;

(k) subject to Section 5.15, all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(l) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, but excluding the Proceedings described on Schedule 3.23 and any other such claims relating to Excluded Assets or the Excluded Liabilities;

(m) general intangibles of the Hospital Businesses, including goodwill;

(n) Seller's provider agreements with Government Payment Programs; and

(o) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Requirements or contractual requirements by which Seller is bound;

(b) all cash, bank accounts, certificates of deposit, treasury bills, treasury notes, marketable securities and other cash equivalents (including the Purchase Price payable to Seller) of Seller or the Hospital Businesses;

(c) all short-term and long-term Investments, except for the Investment interests in the Joint Ventures;

(d) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, malpractice self-insurance fund, working capital trust assets, and assets and investments restricted as to use), donor restricted assets, beneficial interests in charitable trusts, trusts related to employee benefits, and any self-funded worker's compensation deposit of the Hospital Businesses, and accrued earnings on all of the foregoing;

(e) inventory and supplies disposed of or exhausted after the date of this Agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with Section 5.02(e);

(f) Cost Report settlement receivables and all appeals and appeal rights relating thereto;

(g) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture);

(h) all deductions, benefits, claims, refunds, receivables and other rights of Seller relating to Taxes in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this Agreement;

(i) all other current financial assets not included in Net Working Capital and all deferred expenses;

(j) all Immaterial Contracts that are listed or described on Schedule 2.02(j) and all other Contracts that are not Assumed Contracts (including this Agreement and the Closing Documents);

(k) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;

(l) the corporate or trade names set forth on Schedule 2.02(l) and all Intellectual Property rights relating thereto;

(m) all physician loans and receivables other than repayment obligations under Assumed Contracts;

(n) all right, title and interest of Bristol Hospital Development Foundation ("**BHDF**") in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(n);

(o) all insurance proceeds received by Seller or payable to Seller (i) with respect to the Excluded Assets or the Excluded Liabilities, or (ii) that Seller is entitled to retain pursuant to Section 5.15;

(p) the Proceedings described on Schedule 3.23, appeals and other risk settlements of the Hospital Businesses which arose during or relate to a pre-Closing period, and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

(q) any other assets identified on Schedule 2.02(q) or excluded after the execution of this Agreement by mutual written agreement of the parties; and

(r) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03.

2.04. Excluded Liabilities. Except for the Assumed Liabilities, Buyer shall not assume and under no circumstance will Buyer assume or be obligated to pay or assume, and from and after the Closing, none of the Assets will be or become liable for or subject to, any of the Excluded Liabilities, which Excluded Liabilities are and will remain liabilities of Seller, including the following:

(a) all liabilities accrued on the Closing Balance Sheets, to the extent (i) not included in Net Working Capital or (ii) relating to capitalized lease obligations constituting Assumed Contracts;

(b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date;

(c) liabilities or obligations for federal or state income Taxes of Seller or any Affiliate of Seller, including any amounts accrued or incurred by the Hospital Businesses in respect of periods ending on or before the Closing Date, as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;

(d) liabilities or obligations relating to the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract);

(f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or

default on or before the Closing Date of any Assumed Contracts, and (iii) liabilities arising under any Contracts that are not Assumed Contracts;

(g) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 3.23, and Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that allegedly occurred on or before the Closing Date, including those relating to peer review activities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) except for (x) paid time off accruals of the Hired Employees and Extended Illness Bank Obligations, and (y) obligations under Assumed Contracts (including but not limited to Seller's frozen Employee Pension Benefit Plan), liabilities and obligations to Seller's employees, Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods before Closing (whether or not triggered by the transactions contemplated by this Agreement and whether or not imposed by Legal Requirements directly on Buyer as the transferee of the Assets or successor to the Hospital Businesses), including liabilities or obligations arising under any Employee Benefit Plan, EEOC claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller, including arising out of the operation of the Hospital Businesses or ownership of the Assets, with respect to periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this Agreement, including pursuant to third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services or the Connecticut Department of Social Services and recapture of previously reimbursed charges or expenses; and

(l) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Requirement.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and tender the Purchase Price, determined as follows, subject to the adjustments described in Sections 2.05(b) and 2.05(e):

(i) $[50],000,000**,** *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital.

(b) As further described in Sections 2.05(c) and 2.05(d) below, the Purchase Price will be calculated by Buyer and Seller at Closing from the physical count of inventory and supplies conducted pursuant to Section 2.05(c), if available, and the relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available). At Closing, Buyer shall pay the Purchase Price less the book value of any capital leases (as of the Closing), pension liabilities~~, asset~~ of Seller relating to its frozen defined benefit pension plan (as determined by Buyer on a date within five (5) business days prior to the Closing), any accrued post-retirement or other retirement obligations (as determined by Buyer on a date within five (5) business days prior to the Closing) and other Assumed Liabilities (other than those included in Net Working Capital) and as adjusted by the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06, by wire transfer of immediately available funds to the accounts designated by the appropriate recipient as follows:

(i) To Seller, an amount equal to the sum of (A) the amount necessary to defease its outstanding CHEFA Bonds, (B) the amount necessary to repay its outstanding bank debt and satisfy the Indenture, (C) the value of Excluded Liabilities listed on Schedule 2.05(b), and (D) the indemnification reserve under Section 9.09; and

(ii) To the Community Foundation, the remaining balance of the Purchase Price, after the deductions set forth in Section 2.05(b) and after paying the amount due to Seller under subsection (i) above, and which amount received by the Community Foundation shall be used for the following purposes: (A) charitable health care consistent with the Hospital's historic charitable mission, (B) supporting or promoting health care generally in Bristol, Connecticut and its surrounding communities, or (C) with respect to donor restricted assets, a purpose consistent with the intent of the donor.

(c) The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five (5) business days before the Closing Date. Seller shall give Buyer at least five (5) business days prior notice of the date of the count and permit Buyer to monitor the count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, quality and quantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of

the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then for purposes of the Closing, the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets.

(d) The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer. No more than five (5) business days before the Closing Date, Buyer and Seller will agree on the value as of Closing of the prepaid expenses and deposits that Buyer reasonably determines will be usable after Closing.

(e) Within ninety (90) days after the Closing Date, Buyer will deliver to Seller the Closing Balance Sheets together with any proposed revisions in the amount of the prorations to be made pursuant to Section 2.06 (based on paid invoices delivered by Buyer to Seller after the Closing). Except as otherwise provided herein, the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable and doubtful accounts, as used in preparing the Interim Closing Balance Sheets. The Purchase Price will be recalculated (based on clauses (i) and (ii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, and (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(d) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) on the Interim Closing Balance Sheets and on the Closing Balance Sheets. Following the resolution of any disputes pursuant to Section 2.05(f), Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Community Foundation (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five (5) business days after its determination.

(f) If Seller disputes any entry in the Closing Balance Sheets relevant to the calculation of the Purchase Price Adjustment or disputes the value of the inventory and supplies, and such dispute is not resolved to the mutual satisfaction of Seller and Buyer within ninety (90) days after the Closing Date, either Seller or Buyer may submit the dispute to Ernst & Young LLP or to such other independent, certified public accounting firm as Seller and Buyer may then agree in writing, in either case acting as experts and not as arbitrators to resolve the computation or verification of the disputed Closing Balance Sheets entries in accordance with this Agreement and otherwise where applicable in accordance with generally accepted accounting principles consistently applied.

(g) Seller and Buyer will each pay their own respective fees and expenses (including any fees and expenses of their accountants and other representatives) in connection with the resolution of disputes pursuant to this Section 2.05. Notwithstanding the foregoing, the fees and expenses of any accounting firm incurred in connection with the resolution of such disputes will be paid by Seller and Buyer in proportion to the difference between the Purchase Price Adjustment determined by the accounting firm and the respective amounts of the Purchase Price Adjustment asserted by each such party at the time of the initial referral of the dispute to the accounting firm.

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property and with respect to any reduced amount of property Taxes (pursuant to any payment in lieu of taxes or similar agreement), such proration shall be calculated by giving credit to the Seller for any such reduced amount) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer promptly upon Buyer's receipt of such credit and Buyer agrees to promptly take all reasonable actions necessary in order to secure any such credit.

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-profit corporation duly organized and validly existing in good standing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate and member action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of, any liabilities of Seller (other than Excluded Liabilities satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) do not violate any Legal Requirement to which Seller, the Assets, or the Hospital Businesses may be subject; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a material breach or violation of any material Contract to which Seller is a party or by which it is bound.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Subsidiaries and Third Party Rights. Seller has no Subsidiaries other than the Hospital Businesses, and Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its consolidated Subsidiaries, has total assets of $100,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of equity interests owned by Seller or its Affiliate in such Joint Venture and the name of, and percentage of equity interests owned by, third parties in such Joint Venture. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with or rights of any Person to acquire, directly or indirectly, any material assets, or any interest therein, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Tenet Healthcare or Buyer, or an Affiliate thereof, with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance. Seller and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material respects with, all Legal Requirements with respect to the operation of the Hospital Businesses and Seller has timely filed all material reports, data and other information required to be filed with Governmental Authorities or has requested appropriate extensions of such filing deadlines. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor any Subsidiary of Seller is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of the Hospital Businesses in all material respects as of the respective dates thereof and for the periods therein referred to, all in accordance with generally accepted accounting principles, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements to Seller's knowledge, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by generally accepted accounting principles to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, and none of which could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.08. Recent Activities. Since December 31, ~~2012~~2013, and except as set forth on Schedule 3.08:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of business of the Hospital Businesses in accordance with their existing ~~Hospital~~ personnel policies, Seller has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses, or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute and, to Seller's knowledge, no enactment or promulgation of a state or local Legal Requirement or other event or condition, has occurred that has materially adversely affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and Seller has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of $75,000, with a comparable replacement thereof;

(e) no Encumbrance has been imposed on any of the Assets other than Permitted Encumbrances;

(f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of Seller or its Affiliates, or with any Affiliate of any such Person;

(i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Requirement;

(j) Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in *bona fide* commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable. Since December 31, ~~2012,~~2013, Seller has not sold any Accounts Receivable, including Accounts Receivable that have been written off or fully reserved.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Schedule 3.10 includes a depreciation schedule as of a recent date that lists all major items of equipment associated with, or constituting any part of, the Assets. All such major items of equipment are useable for their intended purposes in the ordinary course of the Hospital Businesses and are in working condition, subject to reasonable wear and tear. All medical and leased equipment has been maintained in all material respects in accordance with

manufacturer and lessor requirements, and equipment maintenance logs or journals have been maintained in all material respects in compliance with required accreditation standards.

3.11. Title. Except as provided in Schedule 3.11 and subject to Section 10.03, Seller owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11 and Permitted Encumbrances. At Closing, Seller will convey to Buyer good and valid title to all Assets, free and clear of any Encumbrances other than the Permitted Encumbrances.

3.12. Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a) and Permitted Encumbrances. The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller or any Subsidiary of Seller that is associated with or employed in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and indefeasible fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) Seller has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) To Seller's knowledge, the buildings standing on the Owned Real Property are structurally sound, and in need of no material maintenance or repairs except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. No part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) To Seller's knowledge, except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.17, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise. No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all Permits and requisite certificates of the local board of fire underwriters (or other body exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) (i) Seller has provided to Buyer accurate and complete copies of those leases of which Seller or one of its Subsidiaries is landlord (collectively, the "**Space Leases**"), and (ii) attached to Schedule 3.12(g) is a "rent roll" that sets forth the following information for each of the Space Leases: (A) the names of the current tenants; (B) the rental payments for the then current month under each of the Space Leases; (C) a list of all then delinquent rental payments; (D) a list of all concessions granted to tenants; (E) a list of all tenant deposits and a description of any application thereof; (F) the dates that each of the Space Leases commenced and will expire; (G) the square footage of any such space leased pursuant to the Space Leases; (H) any renewal options available to tenants under the Space Leases; and (I) a list of all uncured material defaults under the Space Leases known to Seller.

(h) There are no tenants or other persons or entities occupying any space in the Owned Real Property, other than pursuant to the Space Leases.

(i) Seller has (i) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a) pursuant to the leases described on Schedule 2.01(b) (the "**Tenant Leases**"), and (ii) provided accurate and complete copies of each of the Tenant Leases. The Leased Real Property comprises all of the real property leased by Seller or any Subsidiary of Seller that is associated with or employed in the operation of the Hospital Businesses.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all Permits required under applicable Environmental Laws, and all such Permits are listed on Schedule 2.01(g). No Environmental Claim is pending or to Seller's knowledge threatened by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any

Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where Seller stores, disposes or arranges for the disposal of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.13(b), (iv) no asbestos is contained in or forms part of any building, building component, structure or office space owned or leased by Seller and used in the conduct of the Hospital Businesses, and (v) no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations or Encumbrances, and, to Seller's knowledge, claims of infringement, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any written notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in Section 3.18(c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). Seller has provided to Buyer a true and complete copy of all such policies and endorsements thereto. With respect to third party insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. All of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since December 31, 2009, Seller has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage

provided thereby. Since December 31, 2009, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and, to Seller's knowledge, not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. The Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately licensed are duly licensed by the appropriate Governmental Authorities and comply in all material respects with the applicable licensing requirements. The Hospital ~~has~~Businesses have complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.17. Government Payment Programs; Accreditation. The Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. The Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through December 31, ~~2012.~~2013, and Cost Reports **[covering periods prior to _____]** have been audited and notices of program reimbursement have been issued for all Cost Report periods through December 31, 2009. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of ~~the Hospital~~Seller under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, to Seller's knowledge, ~~the Hospital~~Seller has not received or submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or the Hospital's participation therein that remains outstanding or unresolved, except as set forth on Schedule 3.17. All Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by Seller under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Seller or its Affiliates and no such incentive payments were remitted due to any fraudulent, negligent or unlawful act or omission of Seller or its Affiliates. Seller has 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**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made in substantially the form and

manner required by CMS and The Joint Commission, respectively. Seller has 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. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. The Hospital is duly accredited, with no contingencies, by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to the Hospital has been made available to Buyer. Seller has delivered to Buyer copies of the most recent accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein.

3.18. Agreements and Commitments. Schedule 3.18 identifies and sets forth certain information regarding Contracts related to the Hospital Businesses in the categories below:

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

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospital, or (iii) any Person that provides marketing services for Seller;

(c) Contracts relating to Intellectual Properties and Information Systems;

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

(e) Contracts with directors, trustees, officers, employees, or other agents of Seller;

(f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;

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

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between Seller and any of the Joint Ventures;

(j) Contracts with municipalities;

(k) Contracts providing for payments based in any manner on the revenue or profits of the Hospital Businesses or the Assets;

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

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

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

3.19. Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f), except as disclosed on Schedule 3.19:

(a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and are enforceable against Seller in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement by and between the parties thereto, unless otherwise noted therein;

(c) all material obligations required to be performed under the Assumed Contracts by Seller, and, to Seller's knowledge, each other party thereto, on or before the date of this Agreement have been performed, and no event has occurred or failed to occur that constitutes, or with the giving of notice, the lapse of time or both would constitute, a material default by Seller under the Assumed Contracts;

(d) no Assumed Contract contains an express prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing; and

(e) subject to obtaining any consents from third parties to any applicable Assumed Contract, the assignment of any Assumed Contract to and assumption of such Assumed Contract by Buyer will not give a third party the right to terminate such Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Except as set forth on Schedule 3.20, since December 31, ~~2012,~~2013, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller except as set forth in Schedule 3.20 or upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all

full-time and part-time non-physician employees of Seller and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates working at the Hospital Businesses (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) All employees, former employees and independent contractors of Seller 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 Legal Requirement, except in each case where a failure to be so classified would not have an adverse effect on the business, assets, liabilities, financial condition, or results of operations of the Hospital Businesses.

(c) Except as set forth in Schedule 3.21(c), Seller has complied in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; Seller is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.21(d) states the number of employees terminated by Seller within ninety (90) days prior to the Closing Date, laid off by Seller within the six (6) months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Seller 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. In relation to the foregoing, except as set forth in Schedule 3.21(d), Seller has not violated the WARN Act or any similar state or local Legal Requirement.

(e) To the knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of Seller in respect of the Hospital Businesses or the Assets; or (ii)

to assign to Seller any rights to any invention, improvement, or discovery. To the knowledge of Seller, no former or current employee of Seller is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as Seller did prior to Closing.

(f) No employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to Seller's knowledge, threatened. No employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place. No complaint, charge or claim is pending or, to Seller's knowledge, threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(g) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To Seller's knowledge, no employee of Seller who is a foreign national has ever worked without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and Seller has complied with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To Seller's knowledge, Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and, where required by law, re-verified all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with federal immigration regulations, including compliance with federal immigration laws. Seller has 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 Seller has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of Seller. If Seller operates in a state or has contracts with a Governmental Authority that requires or provides a safe harbor if an employer participates in the Department of Homeland Security's e-Verify electronic employment verification system, Seller has been participating in e-Verify for the entire period such participation has been required or available as a safe harbor or as long as Seller has been operating in such state or contracting with such Governmental Authority.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any of its Subsidiaries that are members of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals) (each, a "**Current Seller**

Plan"). Except for the Current Seller Plans, Seller has no liability with respect to any Employee Benefit Plan of a member of the Controlled Group that includes Seller.

(b) Each Current Seller Plan, and related trust, insurance contract or fund, complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current Seller Plan and applicable Legal Requirements. With respect to each Current Seller Plan, all required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan, or Seller has requested appropriate extensions of such filing deadlines. Seller has delivered to Buyer, to the extent applicable: copies of the currently effective plan documents and currently effective summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller has maintained, or to which it has contributed or been required to contribute (each, a "**Prior Seller Plan**"), during the five (5) years preceding the date of this Agreement, and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) required to be made by Seller or its Subsidiaries to each Current Seller Plan that is an Employee Pension Benefit Plan that are required to be paid have been paid. To Seller's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal Revenue Service, as applicable. To Seller's knowledge, nothing has occurred with respect to any Current Seller Plan that has subjected or could reasonably be expected to subject Seller, or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a penalty under section 502 of ERISA or to an excise tax under the Code. To Seller's knowledge, with respect to any Current Seller Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject the Seller or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a tax under section 4971 of the Code or the assets of any of the foregoing persons to a lien under section 412(n) of the Code.

(d) Except as provided on Schedule 3.22(d), the requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments for all periods ending on or before the Closing Date for

which the payment deadline has expired have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any liability. To the extent that the Seller, any of its Subsidiaries or any employee thereof is considered an ERISA Fiduciary with respect to any Current Seller Plan or Prior Seller Plan, no such ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or, to Seller's knowledge, threatened and, to Seller's knowledge, there exists no basis for any such Proceeding. No "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Benefit Pension Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.22(f), no Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or, to Seller's knowledge, the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or to Seller's knowledge threatened. Seller has not incurred, and, to Seller's knowledge, no event has occurred prior to the date hereof that will cause Seller to incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) Neither Seller nor any member of a Controlled Group that includes Seller contributes to, has contributed to, or has been required to contribute to, during the six (6) calendar years preceding Closing, any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan.

3.23. Proceedings and Claims. Schedule 3.23 contains a list and summary description of each Proceeding and claim (including *qui tam* Proceedings and claims) pending or, to Seller's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, Seller or any Affiliate of Seller (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or claim). All such Proceedings and claims are or, to Seller's knowledge, will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. To Seller's knowledge, none of the Proceedings or claims described on Schedule 3.23, if determined adverse to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Seller has filed all Tax Returns required to be filed by or on behalf of Seller on or prior to the date of this Agreement, all such Tax Returns are accurate in all material respects, and Seller has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of Seller, threatened. There are no outstanding agreements by Seller for the extension of time for the assessment of any Taxes.

(d) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has ever been made by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction and no Encumbrances have arisen against Seller or the Assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to Seller.

(f) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of Seller and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service regarding such Tax status and, to Seller's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption.

(h) Neither Seller nor any Affiliate of Seller has any liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations. Seller has delivered to Buyer a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of the Hospital. Seller has also delivered to Buyer a list, current as of the date of this Agreement,

that sets forth (i) the name and age of each member of the medical staff of the Hospital (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 of the Hospital, (iii) the names of the medical staff members (current and former) of the Hospital in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three (3) years, and (iv) the number of current medical staff members of the Hospital in respect of 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. No material disputes between Seller and any medical staff member of the Hospital are pending or, to Seller's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. To Seller's knowledge, no member of the medical staff of the Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any liability in respect of funds received by any Person for the purchase, improvement or use of any of the Assets or the conduct of the Hospital Businesses under restricted or conditioned grants or donations, including monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Except for Cain Brothers & Company, LLC, neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. To Seller's knowledge, none of the Hospital Businesses has made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor any officer, director or trustee of Seller has received or will receive as a result of the consummation of the transaction contemplated by this Agreement any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Hospital Businesses and Joint Ventures.

(a) Each of Seller's Subsidiaries (except for EMS) is a corporation duly organized under the laws of the State of Connecticut with full corporate power to carry on its business as it is now being conducted. Each of Seller's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective

assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock or other equity interests of Seller's Subsidiaries (except EMS) are owned as specified on Schedule 3.30(a). All of the issued and outstanding shares of capital stock or other equity interests of Seller's Subsidiaries have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of Seller's Subsidiaries and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of Seller's Subsidiaries and has provided to Buyer a copy of, or access to, the minute books of Seller's Subsidiaries.

(b) EMS is a limited liability company duly organized under the laws of the State of Connecticut with full limited liability company power to carry on its business as it is now being conducted. EMS is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of its assets or properties, or the conduct or nature of its businesses, makes such licensing, qualification or admission necessary. All of the membership interests of EMS are owned as specified on Schedule 3.30(~~b~~a). All of the outstanding membership interests of EMS have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any membership interests of EMS and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of organization and operating agreement and other agreements, instruments and documents relating to the creation, ownership and governance of EMS and has provided to Buyer a copy of, or access to, the minute books of EMS.

(c) Each Joint Venture is a limited liability company organized under the laws of the State of Connecticut with full limited liability company power to carry on its respective business as it is now being conducted. Each of the Joint Ventures is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. Except as set forth in the operating agreements of the Joint Ventures, the transfers to Buyer of the membership interests in the Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer a copy of the articles of organization and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the Joint Ventures, and has provided to Buyer a copy of, or access to, the minute books of the Joint Ventures, to the extent within Seller's possession or control.

3.31. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all material assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in the manner in which they have been operated since December 31, 2011,

except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.31 sets forth a list of the ten (10) largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the year ended December 31, ~~2012.~~2013. Since December 31, ~~2012,~~2013, no payor listed on Schedule 3.31 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

3.32. Full Disclosure. The representations of Seller 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. Seller has provided or made available to Buyer all material documents and information that has been requested by Buyer or its representatives.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization. Buyer is a limited liability company duly organized and validly existing and in good standing under the laws of the State of Delaware. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing.

4.02. Power and Authority; Due Authorization. Buyer has full power and authority to (a) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (b) perform its obligations under this Agreement and such Closing Documents and (c) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary limited liability company action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which Buyer is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within Buyer's limited liability company powers, are not in contravention of its certificate of formation, company agreement or other governing documents, and have been duly approved by all required limited liability company and member action;

(b) do not violate any Legal Requirement to which Buyer is subject; and

(c) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which Buyer is a party or by which it is bound.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer is or becomes a party are (or, upon execution and delivery thereof by Buyer at the Closing, will be), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the respective terms hereof and thereof.

4.05. Governmental Consents. Buyer is not aware of any consent, approval, license or other authorization from any Governmental Authority that it will not obtain prior to Closing, which failure to obtain would prevent the consummation of the transactions contemplated by this Agreement.

4.06. Proceedings and Compliance. There are no claims, actions, suits, proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder, or (e) except as disclosed in Tenet Healthcare's publicly available filings with the Securities and Exchange Commission, could reasonably be expected to result, individually or in the aggregate, in a material adverse change in the business, financial condition, or results of operations of Buyer or its Affiliates. In addition, Buyer and its Affiliates are in compliance with all Legal Requirements with respect to the operation of their businesses, except where the failure to be in compliance would not have a material adverse effect on the conduct of their businesses, taken as a whole, or on the transactions contemplated by this Agreement.

4.07. Government Programs.

(a) There is no existing Corporate Integrity Agreement and/or Settlement Agreement in effect between Buyer or any Affiliate or Subsidiary of Buyer and any Governmental Authority.

(b) Neither Buyer nor any Affiliate or Subsidiary of Buyer is aware of any material matter that could have a material adverse effect on the transactions contemplated by this Agreement or the operation of the Hospital Businesses by Buyer after Closing.

4.08. Availability of Funds. Buyer has the ability to obtain funds in cash in amounts equal to the Purchase Price and necessary to perform its obligations hereunder that are to be performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform its obligations hereunder that are required to be performed as of Closing.

4.09. Solvency. Neither Buyer nor any Affiliate of Buyer has any intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Buyer's or any Affiliate of Buyer's property and no other Person has filed or, to Buyer's knowledge, threatened to file such a petition against Buyer or any Affiliate of Buyer. Neither Buyer nor any Affiliate of Buyer will be rendered insolvent as a result of any of the transactions contemplated by this Agreement.

4.10. Brokers and Finders. Neither Buyer nor any Affiliate of Buyer, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.11. Full Disclosure. The representations of Buyer in this Agreement and the Schedules do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading. Buyer has provided or made available to Seller all material documents and information that has been requested by Seller or its representatives.

5. COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates to:

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses;

(b) use good faith efforts to maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that Seller shall consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) that exceed $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual capital or operating budgets that have been provided to Buyer;

(c) perform in all material respects, when due, all Legal Requirements and obligations under Contracts;

(d) maintain title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances);

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) use good faith efforts to (i) maintain and preserve its business organizations and operations intact, (ii) retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course

of the Hospital Businesses), and (iii) maintain its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses in the ordinary course of the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate to:

(a) amend or terminate any Assumed Contract, or enter into any Contract except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall obtain Buyer's consent on any new Contract (or a series of related Contracts) that has required payments by Seller that exceed $250,000, unless such Contract may be terminated without cause upon no more than ninety (90) days written notice and such termination will not result in any penalty or fee;

(b) enter into any tertiary affiliation other than the Yale Network Member Agreement, a copy of which Seller has provided to Buyer;

(c) increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets other than Permitted Encumbrances;

(e) sell or otherwise transfer or dispose of any material item of property, plant, equipment or other Asset except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof;

(f) distribute any assets other than Excluded Assets, to any Affiliate of Seller that is not one of the Hospital Businesses;

(g) make any capital expenditure in excess of $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual operating or capital budgets that have been provided to Buyer;

(h) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses, 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;

(i) create, incur, assume, guarantee or otherwise become liable for any liability or obligation in excess of $250,000, or agree to do any of the foregoing;

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

(k) amend, change or modify the title or duties of the chief executive officer of Seller;

(l) sell or factor any Accounts Receivable;

(m) change any accounting method, 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 generally accepted accounting principles or applicable Legal Requirements;

(n) terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for amendments required to comply with this Agreement or applicable Legal Requirements;

(o) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of any of the Hospital Businesses or otherwise take any action relating to any liquidation or dissolution of Seller, except as expressly contemplated by this Agreement;

(p) amend or agree to amend the governing documents of any Joint Venture, except immaterial amendments or amendments required to comply with applicable Legal Requirements or to assign and transfer to Buyer Seller's Investment in, or for Buyer to become a partner or member or shareholder of, such Joint Venture; or

(q) take any action outside the ordinary course of the Hospital Businesses.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this Section and in reliance upon the representations of Seller in Sections 3.21 and 3.22, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date all active employees of Seller who work at the Hospital Businesses and are in good standing immediately before Closing, and all employees of Seller who are as of the Closing Date on approved leave, including~~, without limitation,~~ those workers then eligible for and receiving disability, or workers' compensation; provided, that the hire date for any employees on approved leave would be such date as the employee is eligible to return to work. Each such offer shall be on the same terms and conditions with respect to job duties, titles, locations and responsibilities that are applicable to such employees on the date of this Agreement. Buyer shall not reduce the base salaries or wages of the Hired Employees for a period of 12 months after Closing. In addition, Buyer will offer or cause its Affiliates to offer the Hired Employees Employee Benefit Plans consistent with Employee Benefit Plans offered to employees at other hospitals operated by Subsidiaries of Tenet Healthcare in other markets.

(b) Seller acknowledges that, other than employment agreements with physicians which shall be assumed by Buyer or one of Buyer's Affiliates at Closing in accordance with subsection (g) below, all employment offers are for "at will" employment only and are subject to the satisfactory completion by Buyer of Tenet Healthcare's customary employee background checks and pre-employment screenings. Nothing in this Section or elsewhere in this Agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in Section 5.03(a), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, provided that Buyer will assume and honor all severance agreements between Seller and Seller's employees existing as of Closing.

(c) With respect to the Hired Employees and their eligible dependents, Buyer will waive any "pre-existing condition" exclusions in Buyer's paid time-off and Employee Welfare Benefit Plans, to the same extent such exclusions were waived in Seller's Employee Welfare Benefit Plans as of the Closing Date. Buyer will give all Hired Employees credit for their vacation, holiday and sick pay (whether in such form or in the forms of so-called "paid time off" or an "extended illness bank") to the extent the same constitute Assumed Liabilities as set forth on Schedule 2.03. Buyer shall give all Hired Employees credit after Closing for their years of service with Seller for the purpose of determining how much vacation, holiday and sick pay the Hired Employees are entitled to under Buyer's Employee Welfare Benefit Plans and for purposes of determining eligibility to participate and vesting percentages in Buyer's Employee Pension Benefit Plans to the same extent such service was recognized under Seller's Employee Pension Benefit Plans as of the Closing Date. Buyer will not assume or otherwise become liable for, and Seller will remain solely responsible for (i) Seller's Employee Welfare Plans, (ii) long term disability payments to any former employee of Seller who does not actively work for Buyer after Closing, and (iii) any other obligations to former or currently retired employees or their dependents. Buyer will make available group health plan continuation coverage required under COBRA to employees and former employees of Seller and current or former dependents thereof who are eligible for COBRA ("**Seller's COBRA Beneficiaries**"), provided that, with respect to Seller's COBRA Beneficiaries whose qualifying events occurred on or prior to the Closing Date, Seller will reimburse Buyer for all claims of such Seller's COBRA Beneficiaries paid by Buyer and its Affiliates in excess of the sum of (A) COBRA premiums collected from Seller's COBRA Beneficiaries; and (B) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all such Seller's COBRA Beneficiaries. Buyer (or its designated agent) shall timely and properly file all claims incurred by Seller's COBRA Beneficiaries with Buyer's stop loss carrier, and that Seller shall not be liable for any claims of Seller's COBRA Beneficiaries that would have been reimbursed by Buyer's stop loss carrier if such claim had been timely and properly filed by Buyer or its agent.

(d) As of the Closing, Buyer agrees to assume the assets and liabilities of, and administer, Seller's frozen Employee Pension Benefit Plan known as the "Bristol

Hospital & Health Care Group Retirement Plan" and assume all collective bargaining agreements of Seller that pertain to the Hospital Businesses.

(e) Between the date of this Agreement and Closing, Buyer or one of its Affiliates, with the prior written approval of Seller, may run newspaper advertisements or post similar other notices, in the name of any of the Hospital Businesses or in the name of Buyer or one of its Affiliates, to recruit employees for the Hospital Businesses to commence on or after the Closing Date.

(f) At Closing, Seller shall deliver to Buyer a list setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this Agreement and the Closing Date.

(g) This Section shall not apply to employees employed by Seller under Assumed Contracts. Employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(h) Prior to Closing, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after Closing, Buyer will be responsible for compliance by Buyer with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

(i) Seller and its Affiliates shall remain solely responsible, and Buyer shall have no obligations whatsoever, for the Seller's Employee Pension Benefit Plans known as the Bristol Hospital Multi-Specialty Group, Inc. 401(k) Plan and the Bristol Hospital & Health Care Group 403(b) Tax Sheltered Annuity Program, and the distribution of benefits from those plans.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets and books and records relating to the Hospital Businesses, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to Seller. Buyer shall exercise its rights under this Section 5.04(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses. Buyer agrees that no inspections shall take place and no employees or other personnel of the Hospital Businesses shall be contacted by Buyer without Buyer first

providing reasonable notice to Seller and coordinating such inspection or contact with Seller.

(b) Seller will deliver to Buyer:

(i) within twenty-five (25) days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within forty (40) days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) Until the Closing Date, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any personal health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by The Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Due Diligence; Disclaimer.

(a) Buyer acknowledges and agrees that prior to the date of this Agreement, it was afforded the opportunity to conduct all investigations, inspections, interviews, reviews and analysis and other due diligence with respect to the Hospital Businesses and the Assets, including any relating to the financial physical, structural, mechanical,

electrical, environmental and other condition or aspect of the Hospital Businesses, title to the Properties, compliance of the Properties with work orders and zoning, fire and other building requirements, and the Transaction, which the Buyer deemed necessary or desirable (the "**Due Diligence**"), and that such Due Diligence has been completed to Buyer's reasonable satisfaction.

(b) Disclaimer. Buyer acknowledges and agrees that, except as set forth in this Agreement and the Closing Documents, and subject to the representations and warranties herein and therein, the Assets and the Hospital Businesses and all assignments and other aspects of the transactions contemplated herein are being sold and purchased or otherwise dealt with on an "as-is, where-is" basis with respect to their physical condition.

5.06. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five (5) years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies. For purposes of this Agreement, the term "records" includes all documents, electronic data, and other compilations of information in any form. Buyer acknowledges that as a result of entering into this Agreement and operating the Hospital Businesses it will gain access to patient and other information that is subject to state, federal and Seller's own internal rules and regulations regarding confidentiality. Buyer agrees to abide by all applicable laws relating to the confidential information it acquires. Buyer agrees to maintain the patient records delivered to Buyer at the Closing at the Hospital Businesses after Closing to the extent required under applicable law (including, if applicable, Section 1861(v)(i)(I) of the Social Security Act (42 U.S.C. §1395(v)(1)(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 Seller and upon the Buyer's receipt of appropriate consents and authorizations, the Buyer will afford to the representatives of Seller, including its counsel and accountants, reasonable access to, and copies of, the records transferred to Buyer at the Closing (including~~, without limitation,~~ access to patient records in respect of patients treated by Seller at the Hospital Businesses for any reasonable purpose, to the extent permitted by law). In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed from the Hospital Businesses to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) For seven (7) years after the Closing Date, Seller will give Buyer, within thirty (30) days after request, an updated claims history, including losses paid and open reserves, for all professional liability, general liability and workers compensation claims relating to the conduct of the Hospital Businesses on or before the Closing Date.

5.07. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authorities to consummate the transactions contemplated by this Agreement, *provided* that no party may be required (x) to pay any sum to Governmental Authorities other than filing fees or past due amounts, or (y) to agree to divest assets or limit the conduct of its businesses.

(b) Until the Closing Date, each party shall ~~file, if and to the extent required by applicable Legal Requirements,~~provide all reports and other documents required or requested by Governmental Authorities under ~~the HSR Act~~Legal Requirements

concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions~~, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible~~. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the ~~HSR Act~~preceding sentence and shall exchange drafts of the relevant portions of each other's report forms before filing.

(c) Seller shall pay all regulatory filing fees for, and other fees incurred in connection with, licenses, certificates, permits, consents, approvals, authorizations and clearances of Governmental Agencies as may be required for the parties to consummate the transactions contemplated by this Agreement, except for the fees that Buyer is required to pay under Connecticut law.

(d) Seller shall promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, *provided* that no such efforts shall require the expenditure of a material sum of money, incurring of concessions, or initiation of litigation.

(e) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a Contract that supersedes or replaces an existing Contract between Seller and a third party. Such new Contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement Contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such Contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such Contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement Contract did not exist or such assumption of Excluded Liabilities was not required.

5.08. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed one hundred twenty (120) days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses; *provided* that Buyer shall indemnify Seller and its Affiliates in connection with Buyer's use thereof, as set forth in Section 9.03 below. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in

the form of Exhibit C hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications.

5.09. Connecticut Transfer Act. This transaction ~~is~~may be subject to the Transfer Act. Accordingly, if required by Legal Requirements, Seller shall prepare a Transfer Act Form III and the accompanying Environmental Condition Assessment Form ("**ECAF**") for the Hospital Businesses to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Copies of the Form III and the ECAF will be provided to Buyer at least 30 days prior to the Closing Date so that Buyer may review and provide reasonable comments. Seller shall sign the Form III as the "Transferor" and Seller or its designee shall sign the Form III as the "Certifying Party" responsible for completing all the required environmental investigation and remediation at the Hospital Businesses in accordance with the Transfer Act, the Connecticut Remediation Standard Regulations, and other applicable Environmental Laws. Buyer shall sign the Form III as the "Transferee." Seller shall furnish copies of the Form III and the ECAF to Buyer prior to the Closing Date for Buyer's execution. Within ten days after the Closing Date, Seller shall (i) file the fully executed Form III and the ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEP**"); (ii) pay the initial $3,000 filing fee and any subsequent Transfer Act fees; and (iii) provide written confirmation to Buyer that the Transfer Act filing has been completed (with a copy of such filing). Seller or its designee shall conduct and complete any actions required by the CTDEP as a result of the filing of the Form III and the ECAF, as necessary to comply with the requirements of the Transfer Act to obtain written confirmation from CTDEP or a "verification" from a "Licensed Environmental Professional" that the Hospital ~~has~~Businesses have been remediated in full compliance with the Connecticut Remediation Standard Regulations. All undefined terms in this Section 5.09 shall have the meanings set forth in the Transfer Act.

5.10. No-Shop Clause. Until the Closing or earlier termination of this Agreement in accordance with its terms, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or ~~other~~otherwise dispose of all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this Section.

5.11. Noncompetition. For a period of five (5) years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses, including any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, wellness center, urgent care center, ambulatory service, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a thirty (30) mile radius of the Hospital (the "**Restricted Area**"); (ii) employ or solicit the employment of any Hired Employee unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliate after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any Contract for the provision or arrangement of health care services from the Hospital Businesses with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any Contract with or change practice patterns at the Hospital Businesses. Notwithstanding the foregoing, however, Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospital: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services, social welfare, and other non-medical services for women, infants and children or parent/child services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services to be provided by Buyer. In the event of a breach of this Section, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Buyer and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

5.12. Change of Corporate Names. From and after Closing, except as set forth on Schedule 5.12, Seller shall not use the names "*Bristol Hospital*," "*Bristol Hospital Multispecialty Group*," "*Bristol Health Care*," "*Bristol Health*" or any variation of the foregoing or any other Intellectual Property included in the Assets, except as may be necessary to wind up its corporate

affairs and make filings (including Tax Returns) required by Legal Requirements. Notwithstanding the foregoing, Seller may continue to use the name "Bristol Hospital Development Foundation" until such time as the governing board of BHDF determines a new name for such foundation.

5.13. Allocation of Purchase Price. Within one hundred twenty (120) days after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties sixty (60) days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within sixty (60) days after Seller gives its objection to Buyer. If a final resolution is not reached within sixty (60) days after Seller has submitted its objection in writing, Buyer and Seller shall utilize the dispute mechanism described in Section 2.05(f), and the determination of an independent, certified public accounting firm as Seller and Buyer may then agree in writing (such accounting firm entitled to engage any third party valuation experts as necessary in order to determine such allocation) shall be binding on the parties hereto. The Buyer and Seller 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. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the Internal Revenue Service in accordance with such allocation.

5.14. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can reasonably execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands after the Closing that relate to or constitute a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

5.15. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Businesses 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 8.04, (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 Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds (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 Seller and Buyer will determine any reduction in Purchase Price pursuant to such clause (ii). If Buyer fails to make a timely election pursuant to this Section, Buyer shall be deemed to have made the election described in clause (iii) above.

5.16. Seller's Cost Reports. Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this Agreement. Buyer will provide information to Seller and assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in Section 5.13. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within ten (10) business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any amounts receivable or payable in respect of such reports, refunds or reserves relating to the Cost Reports, and the right to appeal any Medicare determinations relating to the Cost Reports.

5.17. Governance Matters.

(a) Buyer shall cause the Local Board Bylaws, in substantially the form attached as Exhibit A hereto, to be adopted and effective as of the Closing Date. Pursuant to the Local Board Bylaws, as of the Closing, there shall be established a ten (10) member Board of Trustees for the Hospital, which shall be comprised of four (4) physicians members of the Hospital Medical Staff, five (5) community leaders selected from among members of Seller's current Board of Directors, including the current Board Chair (the "**Initial Community Directors**"), and the chief executive officer of the Hospital. The members of the initial Local Board are set forth on Schedule 5.17 hereto. For the Initial Five Year Period (defined in Section 5.21 below), the Initial Community Directors (and their successors), together with a Buyer appointee, shall serve as the nominating committee to nominate candidates to fill expired or vacant Initial Community Director

positions on the Local Board. Such nominating committee shall act by majority vote of its members.

(b) Pursuant to the Local Board Bylaws (and as more fully described therein), the Local Board shall be responsible for and make recommendations to Buyer and its Board of Directors regarding the establishment of Hospital policies, the maintenance of patient care quality, and the provision of clinical service and community service planning in a manner responsive to community needs. Buyer agrees that reasonable recommendations of the Local Board will be considered in good faith by the Buyer's Board of Directors. During the Initial Five Year Period, Buyer will obtain approval of the Local Board for any amendment to the Local Board Bylaws that would affect the structure, membership, duties, or authority of the Local Board or change powers reserved to the Local Board, other than amendments that are made to comply with applicable Legal Requirements, governmental guidelines or policies or requirements of accreditation agencies.

(c) As of the Closing, Buyer will hire the current chief executive officer of Seller and the Hospital, and assume his existing employment agreement. During the Initial Five Year Period, (i) Buyer will consult with the Local Board before hiring any successor chief executive officer of the Hospital, and (ii) to the extent consistent with the powers generally delegated to chief executive officers of Tenet Healthcare-affiliated hospitals, Buyer will delegate to the Hospital's chief executive officer the authority to hire/fire the Hospital's management team.

5.18. Preservation of Essential Services and Quality Care. For at least ten (10) years after Closing, Buyer will cause the Hospital Businesses to provide the Essential Services described on Schedule 5.18 in the manner deemed necessary or appropriate in the discretion of the Local Board. During all periods that Buyer, or a Buyer Affiliate or Buyer Subsidiary, controls and operates the Hospital Businesses, Buyer agrees to maintain or enhance Seller's historic commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs, and shall strive to ensure that the Hospital Businesses meet identified targets and goals with respect to regulatory, quality and safety targets and patient experience measures.

5.19. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, during all times that Buyer or a Buyer Affiliate or Buyer Subsidiary owns and operates the Hospital Businesses, Buyer will ensure that the Hospital Businesses maintain and adhere to Seller's current policies on charity care, indigent care and community benefit attached as Schedule 5.19 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as Seller's existing policies. For the Initial Five Year Period, Buyer shall consult with the Local Board with respect to any proposed changes in such policies and procedures, other than changes in such policies and procedures that are made to comply with applicable Legal Requirements or governmental guidelines or policies.

(b) During all times that Buyer or a Buyer Affiliate or Buyer Subsidiary owns and operates the Hospital Businesses, Buyer will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.20. Capital Commitment.

(a) Within five (5) years of Closing and in consultation with the Local Board, Buyer agrees to (i) spend or commit in a binding contract to spend ~~(or~~within a reasonable time period not to exceed six (6) years after the Closing, or (ii) cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend in accordance with the Strategic Business Plan~~)~~ within a reasonable time period not to exceed six (6) years after the Closing, not less than ~~[~~$45,000,000~~]~~ on capital projects, including routine and non-routine capital expenditures, at, or for the benefit of, the Hospital Businesses including, to the extent incorporated in the Strategic Business Plan, the acquisition, development and improvement of hospital, ambulatory or other health care services affiliated with the Hospital.

(b) Notwithstanding the above capital commitment, 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-stock hospitals or other for-profit health care entities, or (ii) causes the Hospital Businesses to suffer a material decline in EBITDA, on a consolidated basis, then, in either event, Buyer shall be required to consult with the Local Board to determine an alternate capital commitment approved by the Local Board and Buyer that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

5.21. Restriction on Sales. As reflected in this Agreement and the Strategic Business Plan prepared in connection herewith, the parties have a shared commitment to ensuring stability and continuity of care, and preserving essential services for the community served by the

Hospital and its residents, from and after the Closing Date. In recognition of such objectives, the parties hereby agree as follows:

(a) During the five (5)-year period immediately following the Closing Date ("**Initial Five Year Period**"), without the prior consent of the Local Board (which consent may not be unreasonably withheld, conditioned, delayed, or denied):

(i) Neither VHS CT nor any Affiliate that owns an equity interest in Buyer shall effect or permit any sale or transfer of all or substantially all of the stock or membership interests in Buyer;

(ii) Neither Buyer nor any Affiliate or Subsidiary of Buyer that owns any assets comprising the Hospital Businesses shall effect or permit any sale or transfer of all or substantial assets used in the operation of the Hospital Businesses, including~~, without limitation,~~ the Investment ~~Interests~~interests in the Joint Ventures (considered in the aggregate with the other assets of the Hospital Businesses); and

(iii) Neither Buyer nor any Affiliate or Subsidiary of Buyer that owns any assets comprising the Hospital Businesses shall effect or permit any merger, consolidation, spin-off, liquidation or dissolution of any entity or entities that own all or substantial assets constituting the Hospital Businesses.

(b) Upon the expiration of the Initial Five Year Period, for a five (5)-year period thereafter ("**Second Five Year Period**"), neither Buyer nor any Affiliate or Subsidiary of Buyer, as the case may be, shall effect or permit any of the actions listed in Sections 5.21(a)(i)-(iii) prior to consulting in a timely manner with the chief executive officer of the Hospital and the Local Board; *provided* that neither Buyer nor any Affiliate or Subsidiary of Buyer must obtain the consent of the Hospital's chief executive officer or Local Board prior to effecting any of the transactions listed in Sections 5.21(a)(i)-(iii) during the Second Five Year Period.

(c) For purposes of this Section, "substantial assets" means assets of Buyer (as such assets may be upgraded, expanded or changed after Closing) which, in the aggregate, produce at least twenty-five percent (25%) of the total revenue of the Hospital Businesses as calculated at the time of the proposed transaction.

(d) For purposes of this Section, "sale or transfer" shall not include the following: (i) any Subsidiary of Tenet Healthcare that owns an equity interest in an entity owning all or a part of the Hospital Businesses pledging such interest or its accounts receivable pursuant to the Principal Credit Agreement, (ii) the lenders under the Principal Credit Agreement or any other indebtedness of Tenet Healthcare (or their agent acting on their behalf) foreclosing upon such equity interest, or (iii) Buyer or its Affiliates transferring any stock, ownership interests or Assets to one or more of its Affiliates. Furthermore, and notwithstanding anything to the contrary in this Section 5.21, this Section shall not apply to (x) any sale or transfer required by a Governmental Authority in which Seller is precluded by law or the Governmental Authority from participating, (y)

any merger, sale, or other transaction that does not relate solely or principally to the Hospital Businesses, or (z) any corporate-level transactions involving Tenet Healthcare's stock or securities, including macro-level mergers, recapitalizations and reorganizations.

(e) The restrictions contained in this Section 5.21 are subject to exceptions as may be agreed to by the Local Board for exigent regulatory requirements and market demands.

5.22. Right of First Refusal in Favor of Seller.

(a) If, during the ten (10)-year period immediately following Closing, Buyer, VHS CT or any other Affiliate of Buyer that owns an equity interest in Buyer or any assets comprising the Hospital Businesses (an "**Offering Party**") receives an Offer that it desires to accept, such Offering Party shall promptly provide a written notice to Seller that describes the material terms of the Offer. If Seller notifies the Offering Party within sixty (60) days (or, if the Offer results from a sale process required by a Governmental Authority, Seller notifies the Offering Party within thirty (30) days, as long as the Governmental Authority sale process permits or can accommodate at least such a thirty (30) day notice period) after the date on which notice of the Offer was given to Seller (the "**Election Period**") that Seller irrevocably elects to purchase the equity interests or assets that are the subject of the Offer (the "**Subject Interest**") for the consideration to be paid to the Offering Party pursuant to the Offer (sometimes referred to hereinafter as an "**Affirmative Election**"), then such election shall be binding upon Seller and the Offering Party. If Seller makes an Affirmative Election, the parties shall negotiate in good faith for thirty (30) days after the Election Period the terms and conditions of a definitive agreement to be executed by the Offering Party and Seller containing the principal terms set forth in the Offer, but otherwise containing substantially the same representations and warranties regarding the Hospital Businesses as are set forth in this Agreement, *provided* that any representations and warranties of the Offering Party about the Hospital Businesses shall relate to Buyer's period of ownership only. If the Offer includes any non-cash consideration, Seller shall be entitled to substitute cash in an amount equal to the fair market value of such non-cash consideration. Seller shall acquire the Subject Interest at a closing to be held within five (5) business days following the date upon which the last material regulatory approval required in connection with the sale of the Subject Interest is obtained, subject to reasonable extensions mutually acceptable to the Offering Party and Seller, *provided* that in no event shall the closing be held later than one hundred eighty (180) days after the Offering Party gives Seller written notice of the Offer. Seller shall have the right, upon written notice to the Offering Party, to assign its purchase rights under this Section 5.22 to a designee of Seller; *provided* that such designee does not compete with Buyer or any Affiliate or Subsidiary of Buyer. Such assignment shall not relieve Seller of its obligations under this Agreement.

(b) If (i) Seller fails to make an Affirmative Election within the Election Period, (ii) after making an Affirmative Election and entering into a definitive agreement with the Offering Party, Seller defaults in its obligation under such definitive agreement to timely purchase the Subject Interest, or (iii) the consent of any Governmental Authority or third party required for the consummation of the sale of the Hospital Businesses to

Seller cannot be obtained (following Seller's use of commercially reasonable efforts to obtain such consent or consents), then the Offering Party may (but shall not be obligated to) sell the Subject Interest to the offeror on the terms and conditions of the Offer within 180 days after the event described in clause (i), (ii) or (iii) above, *provided* that, if such sale to such offeror does not occur on or before the expiration of such 180-day period, then the provisions of this Section shall apply anew with respect to the sale of the Subject Interest thereafter.

5.23. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller or its Affiliates shall bear and pay all expenses incurred by or on behalf of Seller in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any material monetary payment to a third party or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following Closing costs: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all real estate transfer Taxes and sales and use Taxes, documentary stamps and recording fees arising out of the transfer of the Assets, (iii) the premium for Buyer's title insurance policies described in Section 7.06 and (iv) all similar Closing costs. Seller shall pay the cost of all regulatory filing fees, except as otherwise provided in this Agreement.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

5.24. Medical Staff Matters.

(a) To ensure continuity of care in the community, the Hospital's medical staff members in good standing at Closing will have medical staff privileges at the Hospital immediately after the Closing, subject thereafter to the Hospital's medical staff bylaws then in effect, as amended from time to time. Following the Closing Date, Buyer shall involve physicians of the Hospital's medical staff in the strategic and capital planning processes for the Hospital Businesses, to insure that the critical needs of the medical staff are met and that strategic initiatives and investments in the Hospital Businesses are prioritized to meet the needs of physicians who practice at the Hospital and their patients.

(b) For a period of five (5) years after Closing, Buyer agrees to consult with the Local Board prior to (i) replacing a hospital-based medical group or physician unless Buyer is doing so in connection with a for-cause termination under such medical group's or physician's then existing contract, or (ii) placing any Buyer or Buyer Affiliate or Subsidiary-employed physician at any location within the Hospital's service area. For purposes of this Section, the Hospital's "service area" includes the towns of Bristol, Plainville, Wolcott, Southington, and Terryville. For purposes of this Section, "Buyer or Buyer Affiliate or Subsidiary-employed physician" shall not include any physician employed by BHMSG or serving on the medical staff of the Hospital immediately prior to Closing, or employed by BHMSG's successor entity, or serving on the medical staff of the Hospital after Closing.

(c) Buyer shall work together with the physicians on the medical staff of the Hospital to develop the medical staff bylaws, rules and regulations, medical staff committee structure, credentialing plan, and fair hearing plan of the Hospital following the Closing.

(d) Buyer will encourage and support participation by both independent and employed physicians who are members of the Hospital's medical staff in Buyer's or Buyer Affiliate's or Subsidiary's Physician Leadership Council. The initial physicians to serve on the Physician Leadership Council are set forth on Schedule 5.24(d).

5.25. Communications. Buyer and its agents, consultants and employees shall not until Closing, without prior notice to the Seller and without the presence of the Seller or its consent, which shall not be unreasonably withheld, conditioned or delayed, have any communications with the employees, unions, contractors, service providers, suppliers, tenants or prospective tenants, with respect to the Hospital Businesses and Properties.

5.26. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so.

5.27. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at

Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

5.28. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.29. Tail Insurance. On or before the Closing Date, Seller will purchase and obtain an unlimited extended claims reporting provision for all primary and excess insurance policies in force as of the date of this Agreement that cover Seller or the Hospital Businesses and each physician employee of Seller (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement related to all periods prior to the Closing. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder as their interests may appear.

5.30. Strategic Business Plan. Prior to the date of this Agreement, the parties shall collaboratively develop the Strategic Business Plan and associated budget, which shall include (i) opportunities to expand the Hospital Businesses' service lines within the community, (ii) supporting recruitment and retention of primary care and specialty care physicians in the community, and employing or contracting with such physicians by an entity aligned or affiliated with the Hospital, (iii) developing a tertiary affiliation and becoming part of a network or system of health care providers that spans the care continuum, and includes preventive care, ambulatory care, urgent care, acute care, chronic care, post-acute care, behavioral health care, rehabilitation, and home care services accessible to the community, and (iv) developing or obtaining the information technology, medical home and medical management infrastructure to provide patient-centric, population health management and assume financial risk for managing the quality and cost of health care services provided to defined populations in the community. After Closing, Buyer will use commercially reasonable efforts to execute and implement the Strategic Business Plan and associated budget in accordance with its terms, as the Strategic Business Plan and associated budget may be modified by Buyer from time to time; *provided* that any material modification to the Strategic Business Plan and/or associated budget shall be subject to the prior approval of the Local Board.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Buyer was true and correct in all material respects on and as of the date of this Agreement, each of the representations and

warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened in writing to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Attorney General, required for Seller to consummate the transactions contemplated by this Agreement ~~and that all applicable waiting periods under the HSR Act have expired or been terminated~~.

6.04. Redemption of the Bonds/Satisfaction of the Indenture. All actions required to be taken and all conditions required to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, including the CHEFA Bonds, and the satisfaction, discharge, release, and termination of all trust indentures and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have been, or at Closing will be, taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from Foley & Lardner LLP or from a nationally recognized bond counsel with respect to the defeasance of the CHEFA Bonds and the Trust Indenture dated as of January 1, 2002 between CHEFA and the Trustee identified therein to the effect that Seller may transfer and convey the Assets to Buyer free and clear of the Indenture and all Encumbrances created by or in connection therewith.

6.05. Strategic Business Plan. The parties shall have agreed upon the Strategic Business Plan, in a form reasonably satisfactory to Seller.

6.06. ~~Physician Alignment. The Connecticut legislature shall have amended the Connecticut Medical Foundation Act (33 Conn. Gen. Stat. § 182aa *et seq.*) (the "**Foundation Act**") to allow stock corporations and other for-profit entities, whether incorporated or organized in Connecticut or another jurisdiction, to own medical foundations that employ physicians, or the parties shall have found a mutually agreeable alternative structure to facilitate the ability of the~~

~~Buyer and the BHMSG physicians to be clinically aligned. In addition, Seller and Buyer shall have agreed upon the manner in which employed and non-employed members of the Hospital's medical staff will contract with the successor entity to BHMSG for employment or services, as well as the entity that will have payer contracting authority for physicians on the Hospital's medical staff.~~[Reserved.]

6.07. Extraordinary Events. Neither Buyer nor Tenet Healthcare nor any Subsidiary of Tenet Healthcare that directly or indirectly holds any equity interest in Buyer (a) is in receivership or dissolution, (b) has made any assignment for the benefit of creditors, (c) has admitted in writing its inability to pay its debts as they mature, (d) has been adjudicated a bankrupt, (e) has 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 or statute of the United States or any state (and no such petition has been filed against Buyer or Tenet Healthcare or any Subsidiary of Tenet Healthcare that directly or indirectly holds any equity interest in Buyer), or (f) has entered into any Contract to do any of the foregoing on or after the Closing Date.

6.08. Physician Alignment. Tenet Healthcare ~~and Yale-New Haven Health Services Corporation ("YNHHSC")~~ shall have caused a medical foundation (the "Foundation") to be formed in the State of Connecticut. ~~YNHHSC~~Tenet Healthcare or an Affiliate thereof will be the sole member of the Foundation, which will employ licensed physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, including those licensed physicians and other licensed Providers employed by BHMSG immediately prior to the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Seller in this Agreement is true and correct in all material respects on and as of the Closing Date (other than the representations in Section 3.08(l) which shall be correct in all respects).

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of Seller's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by Seller, and approved by Buyer, all in accordance with Section 10.01.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

7.03. Material Adverse Change. Since the date hereof, no Material Adverse Change has occurred and no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Change.

7.04. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) Buyer has received confirmation from all applicable Governmental Authorities that all Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any condition that is materially more burdensome to the operation of the Hospital Businesses after Closing as compared to pre-Closing;

(b) Buyer has received reasonable assurances that the applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the ~~Hospitals~~Hospital, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) Buyer has received (i) all other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospital to a for-profit entity by the Attorney General, required for Buyer to consummate the transactions contemplated by this Agreement ~~and~~, and such consents, approvals, licenses and other authorizations (including any conditions imposed on the transactions by any Governmental Authority) do not impose any materially burdensome condition as a result of which the parties mutually determine not to proceed with the Closing, and (ii) all other material consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to operate the Hospital Businesses after Closing; and

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts that are listed on Schedule 7.04(d) and all other consents, waivers, and estoppels of third parties that are reasonably necessary, in the reasonable opinion of Buyer, to effectively complete the transactions contemplated herein have been obtained and are in a form and substance reasonable satisfactory to Buyer; *provided*, that, to the extent any such consent(s) and/or assignment(s) cannot be obtained after good faith efforts, the parties shall use good faith efforts to place Buyer in the same position as if such consent(s) and/or assignment(s) had been obtained; *provided*, *further* that in no event shall Seller or any Seller Affiliate or Subsidiary be obligated to violate or breach any lease or other agreement in making alternative arrangements or in holding any such Assumed Contract in trust for the use and benefit of Buyer hereunder.

7.05. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state (and no such petition has been filed against any it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.06. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a recognized national title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably acceptable to Buyer and with such endorsements as Buyer may reasonably require, at Buyer's sole cost and expense; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company, at Buyer's sole cost and expense.

7.07. Opinion of Seller's Counsel. Buyer has received an opinion from counsel to Seller, dated as of the Closing Date and addressed to Buyer, in a form reasonably satisfactory to Buyer.

7.08. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture, specifically the CHEFA Bonds, shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in Section 6.04.

7.09. Environmental Assessments. Buyer shall have received a Phase I environmental report, in a form reasonably satisfactory to Buyer and at Buyer's sole cost and expense, on each parcel of Owned Real Property and, at Buyer's option, any portion of the premises forming a part of the Leased Real Property. The parties shall have entered into an Access Indemnity Agreement in connection with such Phase I environmental report, in substantially the form of Exhibit D hereto.

7.10. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.11. Strategic Business Plan. The parties shall have agreed upon the Strategic Business Plan, in a form reasonably satisfactory to Seller.

7.12. Physician Alignment. Tenet Healthcare ~~and YNHHSC~~ shall have caused the Foundation to be formed in the State of Connecticut. ~~YNHHSC~~Tenet Healthcare or an Affiliate thereof will be the sole member of the Foundation, which will employ licensed physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, including those licensed physicians and other licensed Providers employed by BHMSG immediately prior to the Closing Date.

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Hospital Businesses and the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at the office of Foley & Lardner LLP, 111 Huntington Avenue, Boston, Massachusetts at 10:00 a.m., or at such other place and time as the parties may mutually agree, on _____, 2014, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, Tenet Healthcare.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Hospital Businesses and the Assets.

8.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

(e) limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit C attached hereto, fully executed by Seller;

(f) an original or certified copy of the tail insurance policies required by Section 5.29 and receipts evidencing payment of the premiums therefor;

(g) a copy of resolutions duly adopted by the board of directors, trustees or shareholders of Seller, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated therein, certified as in full force and effect as of the Closing Date by the appropriate officers of such Seller;

(h) a certificate of a duly authorized officer of Seller certifying that (i) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(i) a certificate of incumbency for the officers of Seller executing this Agreement and the Closing Documents;

(j) a certificate of existence and good standing for Seller and each of its Subsidiaries from the State of Connecticut, dated the most recent practicable date prior to the Closing Date;

(k) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Joint Ventures, duly endorsed for transfer to Buyer~~[~~, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer~~][NTD: To be discussed];~~

(l) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of Seller or any Affiliate conveying an interest in Owned Real Property to Buyer or its Affiliates, certifying that such entity is not a foreign corporation and is not otherwise a foreign Person;

(m) 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 Assets;

(n) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets, including for all motor vehicles;

(o) all necessary state and local real estate conveyance tax forms duly executed by Seller;

(p) final execution copy of the Transfer Act Form III and ECAF, as more fully described in Section 5.09;

(q) commitments to deliver after Closing in ordinary course UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing;

(r) the opinion of counsel to Seller as provided in Section 7.07;

(s) owner's affidavits, certificates, rent rolls and other documentation that may be reasonably necessary to consummate the transactions contemplated by this Agreement and obtain the title policies required to be issued hereunder; and

(t) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) the portion of the Purchase Price due to Seller, in accordance with Section 2.05(b)(i);

(b) the portion of the Purchase Price due to the Community Foundation, in accordance with Section 2.05(b)(ii);

(c) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities;

(d) the Local Board Bylaws in substantially the form of Exhibit A attached hereto;

(e) the Operating Agreement, in substantially the form of Exhibit B attached hereto, as in effect as of the Closing Date;

(f) a copy of resolutions duly adopted by the boards of directors, members or managers of Tenet Healthcare and Buyer, as appropriate, authorizing and approving the execution and delivery of this Agreement, the Local Board Bylaws, the Operating Agreement, and the other Closing Documents and the consummation of the transactions contemplated therein, certified as in full force and effect as of the Closing Date by the appropriate officers of Tenet Healthcare and Buyer;

(g) a certificate of a duly authorized officer of Buyer certifying that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of Buyer in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(h) a certificate of incumbency for the officers of Tenet Healthcare and Buyer executing this Agreement and the Closing Documents;

(i) a certificate of existence and good standing of Buyer from the State of Delaware, dated as of the most recent practicable date prior to the Closing Date; and

(j) such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the transactions contemplated by this Agreement as set forth in Article 7, following prior

written notice to Seller and sixty (60) days' opportunity to cure; (iii) by Seller, by written notice to Buyer if any event occurs or condition exists which causes Buyer to be unable to satisfy one or more conditions to the obligations of Seller to consummate the transactions contemplated by this Agreement as set forth in Article 6, following prior written notice to Buyer and sixty (60) days' opportunity to cure; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before _____, ~~2014~~2015 (as such date may be extended by mutual agreement of Seller and Buyer); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; (v) by Buyer, pursuant to Section 5.15 hereof; or (vi) by either Buyer or Seller pursuant to Section 10.01 hereof.

(b) In the event that this Agreement is terminated by Buyer or Seller (the "**Terminating Party**") because the other party (the "**Breaching Party**") refuses to close the transactions contemplated by this Agreement in violation of Section 5.27 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, pay to the Terminating Party by wire transfer of immediately available funds to an account designated by the Terminating Party a fee equal to $2,500,000 (the "**Termination Fee**"). The parties acknowledge and agree that the agreements contained in this Section are an integral part of the transaction contemplated by this Agreement and constitute liquidated damages and not a penalty. If the Breaching Party fails to pay the Termination Fee in accordance with the terms of this Section 8.04(b), then the Breaching Party shall pay the costs and expenses (including legal fees and expenses) of the Terminating Party in connection with any action, including the filing of any lawsuit or other legal action, taken to collect payment, together with interest as provided in Section 10.20 from the date such Termination Fee was required to be paid. Notwithstanding anything to the contrary in this Agreement, the Terminating Party's right to receive payment of the Termination Fee pursuant to this Section 8.04(b), and the right to receive the payment of its costs and expenses as provided in this Section 8.04(b), shall be the sole and exclusive remedy of the Terminating Party against the Breaching Party and its Affiliates for any and all Losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with this Section 8.04(b), neither the Breaching Party nor any of its Subsidiaries or Affiliates or their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(c) If this Agreement is validly terminated pursuant to this Section 8.04, this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of

Section 5.23 and the confidentiality provisions of Section 10.22 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Subsidiary or Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent, provided in this Article 9, from and after the Closing, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof;

(b) any breach or nonfulfillment of any covenant or agreement of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(c) the Excluded Liabilities; and

(d) any actual damages (including attorneys' fees) resulting from claims by any creditor of Seller relating to a claim in existence as of the Closing Date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable state or federal insolvency, bankruptcy, bulk sales, fraudulent conveyance or creditors' rights Legal Requirements.

9.02. Seller's Limitations.

(a) Seller will have no liability under Section 9.01(a) and no claim will accrue against Seller under Section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 9.01(a) exceeds $500,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.01(a) in excess of the Seller Deductible, *provided* that liability of Seller shall arise for all Losses resulting from Seller's intentional misrepresentation or fraud in the

inducement as between the parties in connection with the entry by the parties into this Agreement.

(b) The aggregate liability of Seller to Buyer's Indemnified Persons for indemnification under Section 9.01(a) shall not exceed $10,000,000 except that there shall be no limitation of Seller's liability for indemnification under Section 9.01(a) in respect of Losses resulting from Seller's intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

(c) In no event shall the Community Foundation be deemed an indemnitor hereunder.

9.03. Indemnification by Buyer. Subject to and to the extent provided in this Article 9, from and after the Closing Date, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof;

(b) any breach or nonfulfillment of any covenant or agreement of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities;

(d) Buyer's use of Seller's licenses and registrations relating to controlled substances and the operation of pharmacies and laboratories under Section 5.08 hereof, as provided in the limited powers of attorney executed by the parties; and

(e) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

9.04. Buyer's Limitations.

(a) Buyer will have no liability under Section 9.03(a) and no claim will accrue against Buyer under Section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 9.03(a) exceeds $500,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

(b) The aggregate liability of Buyer to Seller's Indemnified Persons for indemnification under Section 9.03(a) shall not exceed $10,000,000, except that there

shall be no limitation of Buyer's liability for indemnification under Section 9.03(a) in respect of Losses resulting from Buyer's intentional misrepresentation or fraud in the inducement as between the parties in connection with the entry by the parties into this Agreement.

9.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 9 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonably accurate summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within fifteen (15) days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within fifteen (15) days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee if such settlement includes any non-monetary relief or does not include a full release of the Indemnitee). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, with prior written notice to the Indemnifying Party and at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not reasonably likely to be prejudicial to the Indemnifying Party (it being understood that, except as provided in Section 9.05(a)(ii), if an Indemnitee takes any such action that is

prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. If (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more Buyer's Indemnified Persons and one or more Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, then either (a) the Indemnifying Party shall retain separate counsel with respect to each such party, or, if Indemnifying Party fails to retain such separate counsel in a timely manner, Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the reasonable expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim (following written notice from the Indemnitee and a reasonable opportunity to cure), or if the Indemnifying Party is precluded by the last sentence of Section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided*, however, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld) and (B) the reasonable out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates), and *provided*, *further* that the

Indemnifying Party shall be entitled to may participate in, but not control, any defense or settlement of any Third Party Claim contested by the Indemnitee hereunder.

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within thirty (30) days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the thirty (30)-day period in which to respond pursuant to Section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within sixty (60) days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such sixty (60)-day period, it shall be resolved pursuant to Section 10.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within ten (10) days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 10.20.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the

giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 9.05(a)(i) and Section 9.05(b)(i), as applicable.

9.06. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of Buyer to investigate the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations, warranties and covenants of the other in this Agreement. The representations, warranties and covenants of Seller and Buyer in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 2.04, 3.01, 3.02, 3.03, 4.01, 4.02, 4.04, 8.04(b), 8.04(c), 8.04(d), 9.01(c)-(d), 9.03(c)-(e), 10.15, 10.22 and 10.23; (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.11, 3.12(a) and 3.13; and (c) until the second anniversary of the Closing Date in the case of all other representations, warranties and covenants, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before the expiration of such representation or covenant until the claim for indemnification has been satisfied or otherwise resolved as provided in this Article;

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, or intentional nonfulfillment or breach of any covenant in this Agreement or any Closing Document, all representations, warranties and covenants that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until sixty (60) days after the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach; and

(iii) covenants to be performed or complied with after the Closing Date will survive the Closing until sixty (60) days after the end of the term specified therein, or, if no term is specified, indefinitely.

9.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance

policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any third party claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

9.08. Disclaimer of Special Damages. Notwithstanding anything to the contrary set forth in this Agreement, no Indemnifying Party or other party to this Agreement shall be liable to or otherwise responsible to any Indemnitee for exemplary, punitive, consequential, indirect, incidental or other special damages (including loss of revenue, income or profits) for any matter indemnifiable hereunder or otherwise arising out of or relating to this Agreement or the transactions contemplated hereby, unless such damages are incurred in connection with a Third Party Claim.

9.09. Indemnity Reserve. Seller agrees to maintain an indemnity reserve in the amount of $2,500,000 for a period of three (3) years after the Closing so that Buyer will have meaningful financial recourse against Seller for indemnification claims. Notwithstanding the foregoing, however, if one or more indemnification claims is initiated by Buyer within the three-year indemnification reserve period, then the indemnification reserve shall be extended for an additional period beginning on the date the last claim was initiated during such three (3)-year reserve period and ending upon the later of (i) the final resolution of all claims initiated by Buyer and (ii) the first anniversary of such last claim made during the three-year reserve period.

9.10. Exclusive Remedy. From and after the Closing, except in cases of fraud or intentional misrepresentation or equitable relief sought pursuant to Section 10.02, the rights to indemnification pursuant to this Article 9 will be the sole and exclusive remedy of the parties to this Agreement with respect to any and all matters arising out of or relating to this Agreement or the transactions contemplated hereby. This Section does not preclude or limit the operation of Section 10.04 with respect to any dispute covered thereby nor does this Section preclude or limit any party from initiating or otherwise participating in any Proceeding otherwise permitted by this Agreement to interpret or enforce the parties' respective rights, remedies and obligations pursuant to this Article 9.

10. GENERAL

10.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, Seller and Buyer shall update its Schedules as reasonably necessary, such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for

herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner. If Buyer, in its reasonable discretion, determines that it should not consummate the transactions contemplated by this Agreement because of any information contained in a Schedule, Exhibit, or other instrument that is delivered to Buyer after the execution of this Agreement, then Buyer may terminate this Agreement on or before the Closing by giving written notice thereof to Seller.

(b) Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself). Disclosure of an exception under one schedule is sufficient for full disclosure by the Seller. It shall not be necessary to make the same disclosure under multiple schedules so long as the intent for information disclosed under one schedule to apply to multiple schedules is readily apparent.

10.02. Equitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 9).

10.03. Other Owners of Assets. Buyer, Seller and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to, such Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or

controls the Assets to be a party to this Agreement. The provisions of this Section 10.03 shall not apply to BHDF.

10.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 10.14 hereof, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 10.04(a) within thirty (30) days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within fifteen (15) days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Any mediation conducted hereunder shall be held in Bristol, Connecticut. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of sixty (60) days, unless a longer period is otherwise agreed.

10.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

10.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may, subject to Section 10.22 hereof, be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

10.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller and Buyer shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such Contract, claim or right. In no event shall Seller be required to incur material costs, initiate litigation or accept a concession in order to obtain any consent.

10.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Bristol, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Bristol, Connecticut are permitted or required to be closed.

10.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

10.10. Choice of Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any 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.

10.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate an Affiliate to purchase any or all of the Assets, including the Hospital Businesses, *provided* that Tenet Healthcare shall unconditionally guarantee any and all obligations of such Affiliate pursuant to Section 10.23, and (ii) Buyer and Tenet Healthcare shall be permitted to grant a security interest in and collaterally assign and transfer all of their rights, interests and benefits, but not their obligations, under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of the Seller. Buyer shall cause any Person that acquires, directly or indirectly, a controlling interest in Buyer, whether through the purchase of all or substantially all of the assets of the Hospital Businesses, a purchase of equity or a merger or consolidation, to

assume, honor and perform Buyer's obligations hereunder, in accordance with the terms of this Agreement; provided, that if the acquisition of the controlling interest in Buyer is through an equity purchase, then Buyer agrees that its obligations under this Agreement and the Ancillary Agreements will not be excluded from such transaction.

10.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms.

10.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

10.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: **[VHS Bristol Health System]**, LLC
c/o Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
Attn: Keith B. Pitts
Fax:_____
Email: ~~kpitts@vh.tenethealth.com~~keith.pitts@tenethealth.com

with a copy to (which shall not constitute notice):

Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
Attn: General Counsel
Fax: 469.893.7147
Email: audrey.andrews@tenethealth.com

If to Seller: Bristol Hospital and Health Care Group, Inc.
41 Brewster Road
Bristol, CT 06010
Attn: Kurt A. Barwis, FACHE,
President and Chief Executive Officer
Fax:_____
Email: kbarwis@bristolhospital.org

with a copy to (which shall not constitute notice):

Foley & Lardner LLP
111 Huntington Avenue
Suite 2600
Boston, MA 02199-7610
Attn: Michael L. Blau, Esq.
Fax: 617.342.4001
Email: ~~mblau@foley.com~~mblau@foley.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

10.15. Misdirected Payments; Physician Loans. After Closing, (a) Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates) constituting or in respect of the Assets and Assumed Liabilities, and (b) Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. If Buyer suffers any deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence), Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. Any amounts payable pursuant to this Agreement that are due Buyer by Seller or one of its Affiliates, or due Seller by Buyer or one of its Affiliates, may be

offset against monies or other funds owed by the party entitled to receive payment to the party required to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause its Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

10.16. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

10.17. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate governmental agencies shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

10.18. Entire Agreement; Amendment. Except as set forth in Section 10.22(a), this Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 9.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

10.19. Counterparts; Transmission by Electronic Means. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed

counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

10.20. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A., during such period plus three percent *per annum*.

10.21. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

10.22. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements, Seller and Buyer (and their respective Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party. With respect to information provided by a party to the other party in connection with and relative to this proposed transaction, the Confidentiality Agreement, dated January 9, 2012, between Vanguard Health Systems, Inc. and Seller shall remain in full force and effect during the term hereof, shall survive termination of this Agreement, and shall be binding upon Buyer for purposes of confidentiality. It is understood by the parties hereto that the information, documents, and instruments delivered by a party to the other party hereto are of a confidential and proprietary nature. Buyer and Seller shall comply with and recognize all confidentiality and non-disclosure requirements that apply to Seller 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 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. Each of the parties hereto recognizes that any breach of this Section 10.22 would result in irreparable harm to the other party to this Agreement and its 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.

(b) At all times before and after the Closing, Seller, on the one hand, and Tenet Healthcare and Buyer, on the other hand, will use good faith efforts to obtain the

other party's prior approval of the text of any public report, statement or release with respect to this Agreement or the transactions contemplated by this Agreement to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

10.23 Guarantee of Buyer's Obligations. Tenet Healthcare, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, Tenet Healthcare will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 9.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. Tenet Healthcare's obligations under this Section 10.23 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

[*Signature Page Follows*]

In Witness Whereof, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

Bristol Hospital and Health Care Group, Inc.

By: _____

Title: _____

[VHS Bristol Health System], LLC

By: _____

Title: _____

TENET HEALTHCARE CORPORATION

By: _____

Title: _____

VHS OF CONNECTICUT, LLC

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 10.03.

ACKNOWLEDGED BY:

BRISTOL HOSPITAL, INC.

By: _____

Title: _____

BRISTOL HOSPITAL MULTISPECIALTY GROUP, INC.

By: _____

Title: _____

BRISTOL HOSPITAL EMS, LLC

By: _____

Title: _____

BRISTOL HEALTH CARE, INC.

By: _____

Title: _____

Exhibits to be attached:

Exhibit A	Local Board Bylaws
Exhibit B	Operating Agreement
Exhibit C	Form of Limited Power of Attorney
Exhibit D	Access Indemnity Agreement

Document comparison by Workshare Compare on Tuesday, July 01, 2014 6:56:10 PM

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Padding cell	

Statistics:	
	Count
Insertions	75
Deletions	115
Moved from	1
Moved to	1
Style change	0
Format changed	0
Total changes	192

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 12: TENET 2013 10-K

FORM 10-K

TENET HEALTHCARE CORP - THC

Filed: February 24, 2014 (period: December 31, 2013)

Annual report with a comprehensive overview of the company

Table of Contents

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
9⅞% Senior Notes due 2014	New York Stock Exchange
9¼% Senior Notes due 2015	New York Stock Exchange
6⅞% 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.

Table of Contents

TABLE OF CONTENTS

		Page
PART I		
Item 1.	Business	1
Item 1A.	Risk Factors	23
Item 1B.	Unresolved Staff Comments	32
Item 2.	Properties	32
Item 3.	Legal Proceedings	32
Item 4.	Mine Safety Disclosures	32
PART II		
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	33
Item 6.	Selected Financial Data	35
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	36
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	87
Item 8.	Financial Statements and Supplementary Data	88
	Consolidated Financial Statements	91
	Notes to Consolidated Financial Statements	96
	Supplemental Financial Information	130
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	131
Item 9A.	Controls and Procedures	131
Item 9B.	Other Information	131
PART III		
Item 10.	Directors, Executive Officers and Corporate Governance	132
Item 11.	Executive Compensation	132
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	132
Item 13.	Certain Relationships and Related Transactions, and Director Independence	132
Item 14.	Principal Accounting Fees and Services	132
PART IV		
Item 15.	Exhibits and Financial Statement Schedules	133

Table of Contents

PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is an investor-owned company whose subsidiaries and affiliates operate regionally focused, integrated health care delivery networks with a significant presence in several large urban and suburban markets. At the core of our networks are acute care and specialty hospitals that, together with our strategically aligned outpatient facilities and related businesses, allow us to provide a comprehensive range of health care services in the communities we serve. As of December 31, 2013, we primarily operated 77 hospitals, 183 outpatient centers, six health plans, six accountable care networks and Conifer Health Solutions, LLC ("Conifer"), which provides business process solutions to more than 700 hospital and other clients nationwide. On October 1, 2013, we completed our previously announced acquisition of Vanguard Health Systems, Inc. ("Vanguard"), an investor-owned hospital company whose operations complemented our existing business. Through this acquisition, we significantly increased our scale, became more geographically diverse, and expanded the services we offer.

With respect to our hospitals and outpatient facilities, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology to remain competitive, to recruit and retain physicians, to expand our outpatient business, and to negotiate favorable contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communications and engagement solutions to optimize the relationship between providers and patients. In addition, our management services offerings have expanded to support value-based performance through clinical integration, financial risk management and population health management. For financial reporting purposes, our business lines are classified into two separate reportable business segments — hospital operations and other, and Conifer. Financial and statistical information about our business segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

We are committed to providing the communities our hospitals, outpatient centers and other health care facilities serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our shareholders. Our operating strategies for accomplishing this mission in the complex and competitive health care industry are discussed in detail in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. In general, we anticipate the continued acceleration of major industry trends we have seen emerge over the last several years, and our strategies reflect the belief that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically and financially; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of an improved economy, shifting demographics and the expansion of coverage under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act"); and (5) payer reimbursements will be constrained and further shift to being more closely tied to performance on quality and service metrics. We believe that our strategies and the acceleration of these trends will allow us to achieve our operational and financial targets. We adjust our strategies as necessary in response to changes in the economic and regulatory climates in which we operate and the results achieved by our various efforts.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER

Hospitals, Outpatient Centers and Related Businesses —At December 31, 2013, our subsidiaries operated 77 hospitals, including four academic medical centers, two children's hospitals, three specialty hospitals and a critical access hospital, with a total of 20,293 licensed beds, serving primarily urban and suburban communities in 14 states. Of those hospitals, 72 were owned by our subsidiaries, and five were owned by third parties and leased by our subsidiaries. We are also in the process of constructing the new Resolute Health Hospital and Wellness Campus in New Braunfels, Texas, which is expected to be completed in or around May 2014. In addition, at December 31, 2013, our subsidiaries operated a long-term acute care hospital and owned or leased and operated a number of medical office buildings, all of which were located on, or nearby, our hospital campuses. Furthermore, our subsidiaries operated 183 free-standing and provider-based outpatient centers in 16 states at

Table of Contents

December 31, 2013, including diagnostic imaging centers, ambulatory surgery centers, urgent care centers and satellite emergency departments, among others. We also owned over 500 physician practices at December 31, 2013.

We seek to operate our hospitals, outpatient centers and related businesses in a manner that positions them to compete effectively in an evolving health care environment. From time to time, we build new hospitals and outpatient centers, and make strategic acquisitions of hospitals, outpatient businesses, physician practices, and other health care assets and companies — in each case in markets where we believe our operating strategies can improve performance and create shareholder value. We believe that growth by strategic acquisitions, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. Moreover, we continually evaluate collaboration opportunities with outpatient facilities, health care providers, physician groups and others in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality service across the care continuum. During the year ended December 31, 2013, we acquired 28 hospitals (plus the New Braunfels hospital under construction) and 39 outpatient centers, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. In addition, in May 2013, we entered into a partnership with John Muir Health through which we will jointly develop and expand outpatient services and physician relationships to improve the efficiency and coordination of care in the Tri-Valley area and nearby communities in Northern California. Furthermore, we have signed a definitive agreement to acquire Emanuel Medical Center, a 209-bed hospital located in Turlock, California. We also sometimes decide to sell, consolidate or close certain facilities to eliminate duplicate services or excess capacity or because of changing market conditions or other factors.

Our hospitals classified in continuing operations for financial reporting purposes generated in excess of 90% of our net operating revenues before provision for doubtful accounts for all periods presented in our Consolidated Financial Statements. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related health care facilities include, but are not limited to: (1) the business environment, economic conditions and demographics of local communities in which we operate; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local health care competitors; (8) managed care contract negotiations or terminations; (9) the number of patients with high-deductible health insurance plans; (10) any unfavorable publicity about us that impacts our relationships with physicians and patients; (11) changes in health care regulations and the participation of individual states in federal programs; and (12) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most offer intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals also offer tertiary care services such as open-heart surgery, neonatal intensive care and neurosciences. Five of our hospitals — Good Samaritan Medical Center, Hahnemann University Hospital, Harper University Hospital, North Shore Medical Center and St. Louis University Hospital — offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Children's Hospital of Michigan and St. Christopher's Hospital for Children provide tertiary and quaternary pediatric services, including bone marrow and kidney transplants, as well as burn services. A number of our hospitals also offer advanced treatment options for patients — Good Samaritan Medical Center, North Shore Medical Center, Sierra Medical Center and Sierra Providence East Medical Center offer gamma-knife brain surgery; and Brookwood Medical Center, North Shore Medical Center, Saint Vincent Hospital at Worcester Medical Center and St. Louis University Hospital offer cyberknife radiation therapy for tumors and lesions in the brain, lung, neck, spine and elsewhere that may previously have been considered inoperable or inaccessible by traditional radiation therapy. In addition, our hospitals will continue their efforts to develop and deliver those outpatient services that can be provided on a quality, cost-effective basis and that we believe will meet the needs of the communities served by the facilities.

Many of our hospitals also offer a wide range of clinical research studies, giving patients access to innovative care. We are dedicated to helping our hospitals participate in medical research that is consistent with state and federal regulations and provides good clinical practice guidelines. Clinical research programs relate to a wide array of ailments, including cardiovascular disease, pulmonary disease, musculoskeletal disorders, neurological disorders, genitourinary disease and various cancers, as well as medical device studies. By supporting clinical research, our hospitals are actively involved in medical advancements that can lead to improvements in patient safety and clinical care.

Except as set forth in the table below, each of our acute care hospitals is accredited by The Joint Commission (formerly, The Joint Commission on Accreditation of Healthcare Organizations). With such accreditation, our hospitals are

Table of Contents

deemed to meet the Medicare Conditions of Participation and are eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs.

The following table lists, by state, the hospitals owned or leased and operated by our subsidiaries as of December 31, 2013:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	631	Owned
Arizona			
Arizona Heart Hospital(1)	Phoenix	59	Owned
Arrowhead Hospital	Glendale	217	Owned
Maryvale Hospital	Phoenix	232	Owned
Paradise Valley Hospital	Phoenix	136	Owned
Phoenix Baptist Hospital	Phoenix	221	Owned
West Valley Hospital	Goodyear	164	Owned
California			
Desert Regional Medical Center(2)	Palm Springs	387	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
John F. Kennedy Memorial Hospital	Indio	156	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center(3)	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
North Shore Medical Center — FMC Campus	Lauderdale Lakes	459	Owned
Palm Beach Gardens Medical Center(4)	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
Saint Mary's Medical Center	West Palm Beach	464	Owned
West Boca Medical Center	Boca Raton	195	Owned
Georgia			
Atlanta Medical Center	Atlanta	762	Owned
Atlanta Medical Center — South Campus(5)	East Point	—	Owned
North Fulton Regional Hospital(6)	Roswell	202	Leased
Spalding Regional Hospital	Griffin	160	Owned
Sylvan Grove Hospital(7)	Jackson	25	Leased
Illinois			
Louis A. Weiss Memorial Hospital	Chicago	236	Owned
MacNeal Hospital	Berwyn	373	Owned
West Suburban Medical Center	Oak Park	234	Owned
Westlake Hospital(8)	Melrose Park	242	Owned
Massachusetts			
MetroWest Medical Center — Framingham Union Hospital	Framingham	147	Owned
MetroWest Medical Center — Leonard Morse Hospital	Natick	122	Owned
Saint Vincent Hospital at Worcester Medical Center	Worcester	321	Owned

Table of Contents

Hospital	Location	Licensed Beds	Status
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	298	Owned
Harper University Hospital	Detroit	567	Owned
Huron Valley-Sinai Hospital	Commerce Township	153	Owned
Hutzel Women's Hospital(9)	Detroit	—	Owned
Rehabilitation Institute of Michigan(1)	Detroit	94	Owned
Sinai-Grace Hospital	Detroit	404	Owned
DMC Surgery Hospital(1)	Madison Heights	67	Owned
Missouri			
Des Peres Hospital	St. Louis	143	Owned
St. Louis University Hospital	St. Louis	356	Owned
North Carolina			
Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center(10)	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher's Hospital for Children	Philadelphia	189	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital — Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake	Dallas	218	Owned
Houston Northwest Medical Center(11)	Houston	430	Owned
Lake Pointe Medical Center(12)	Rowlett	112	Owned
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
North Central Baptist Hospital	San Antonio	340	Owned
Northeast Baptist Hospital	San Antonio	379	Owned
Park Plaza Hospital	Houston	444	Owned
Providence Memorial Hospital	El Paso	508	Owned
Sierra Medical Center	El Paso	349	Owned
Sierra Providence East Medical Center	El Paso	110	Owned
St. Luke's Baptist Hospital	San Antonio	282	Owned
Valley Baptist Medical Center — Brownsville(13)	Brownsville	280	Owned
Valley Baptist Medical Center(13)	Harlingen	586	Owned
Total Licensed Beds		**20,293**	

(1) Specialty hospital.
(2) Lease expires in 2027.
(3) Owned by a limited liability company formed as part of a joint venture with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other health care services in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2013 and is the managing member, and John Muir Health owned a 49% interest.
(4) Lease expires in February 2017, but may be renewed through at least February 2037, subject to certain conditions contained in the lease.
(5) Licensed beds for Atlanta Medical Center — South Campus are presented on a combined basis with Atlanta Medical Center.
(6) Lease expires in February 2020, but may be renewed through at least February 2040, subject to certain conditions contained in the lease.

Table of Contents

(7) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation. The current lease term for this facility expires in December 2016, but may be renewed through December 2046, subject to certain conditions contained in the lease.
(8) Accredited by the American Osteopathic Association.
(9) Licensed beds for Hutzel Women's Hospital are presented on a combined basis with Harper University Hospital.
(10) Lease expires in February 2022, but may be renewed through at least February 2042, subject to certain conditions contained in the lease.
(11) Owned by a limited liability company in which a Tenet subsidiary owned an 86.69% interest at December 31, 2013 and is the managing member.
(12) Owned by a limited liability company in which a Tenet subsidiary owned a 94.674% interest at December 31, 2013 and is the managing member.
(13) Indirectly owned by a limited liability company formed as part of a joint venture with VB Medical Holdings (formerly known as Valley Baptist Medical Center — Brownsville), a Texas non-profit corporation; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2013 and is the managing member, and VB Medical Holdings owned a 49% interest.

The following table presents the number of hospitals operated by our subsidiaries, as well as the total number of licensed beds at those facilities, at December 31, 2013, 2012 and 2011:

	December 31,		
	2013	2012	2011
Total number of facilities(1)	77	49	50
Total number of licensed beds(2)	20,293	13,216	13,453

(1) Includes all general and specialty hospitals and our critical access hospital, as well as one facility at December 31, 2011 that is classified in discontinued operations for financial reporting purposes as of December 31, 2013 and 2012.
(2) Information regarding utilization of licensed beds and other operating statistics can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

As of December 31, 2013, we also owned 183 free-standing and provider-based outpatient centers in 16 states — typically at locations complementary to our hospitals — including diagnostic imaging centers, ambulatory surgery centers, urgent care centers and satellite emergency departments, among others. Most of these outpatient centers are in leased facilities, and a number of outpatient facilities are owned and operated by joint ventures in which we hold a majority equity interest. The largest concentrations of our outpatient centers were in those states where we had the largest concentrations of licensed hospital beds, as of December 31, 2013, as shown in the table below:

	% of Outpatient Centers	% of Licensed Beds
Texas	31.7%	25.7%
Florida	16.4%	17.1%
California	16.4%	11.5%

Strong concentrations of hospital beds and outpatient centers within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Health Plans and Accountable Care Networks—During the year ended December 31, 2013, we acquired five health plans with approximately 140,000 members through our acquisition of Vanguard:

- VHS Phoenix Health Plan, LLC, a Medicaid-managed health plan operating as Phoenix Health Plan ("PHP") in Arizona;
- Phoenix Health Plans, Inc. (formerly known as Abrazo Advantage Health Plan, Inc.), a Medicare and Medicaid dual-eligible managed health plan operating in Arizona;
- Chicago Health System, Inc. ("CHS"), a contracting entity for inpatient and outpatient services provided by MacNeal Hospital, Louis A.Weiss Memorial Hospital and participating physicians in the Chicago area;
- Harbor Health Plan, Inc. (formerly known as ProCare Health Plan, Inc.), a Medicaid-managed health plan operating in Michigan; and
- Valley Baptist Insurance Company ("VBIC"), which is currently in the process of changing its name to Allegian Health Plan, offers health maintenance organization ("HMO"), preferred provider organization ("PPO"), and self-funded products to its members in the form of large group, small group and individual product offerings in south Texas. As of January 1, 2014, VBIC also offers a Medicare Advantage health plan.

Table of Contents

We also own Golden State Medicare Health Plan, which is an HMO that specializes in the care of seniors in Southern California who are eligible for benefits under the Medicare Advantage program.

We believe these health plans complement and enhance our market position and provide us with expertise that we expect will be increasingly important as the health care industry evolves. Specifically, PHP provides us with insights into state initiatives to manage the Arizona Medicaid population, which is valuable in light of the expansion of health coverage to currently uninsured patients pursuant to the Affordable Care Act and various other health care reform laws. In addition, through CHS, our Chicago-based preferred provider network, we manage capitated contracts covering inpatient, outpatient and physician services. We believe our ownership of CHS allows us to gain additional experience with risk-bearing contracts and delivery of care in low-cost settings, including our network of health centers.

We also own or control six accountable care networks — in Florida, California, Illinois, Michigan and Texas — and participate in two additional accountable care networks through collaborations with other health care providers in our markets in Arizona and Massachusetts. These networks operate using a range of payment and delivery models that seek to align provider reimbursement in a way that encourages improved quality metrics and efficiencies in the total cost of care for an assigned population of patients through cooperation of the providers. We believe that our experience operating health plans and accountable care networks gives us a solid framework upon which to build and expand our population health strategies.

CONIFER

Our Conifer subsidiary provides a number of services primarily to health care providers to assist them in generating sustainable improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. At December 31, 2013, Conifer provided one or more of the business process services described below from 20 service centers to more than 700 Tenet and non-Tenet hospital and other clients in over 40 states.

Revenue Cycle Management—Conifer provides comprehensive operational management for patient access, health information management, revenue integrity and patient financial services, including:

- centralized insurance and benefit verification, financial clearance, pre-certification, registration and check-in services;
- financial counseling services, including reviews of eligibility for government health care programs, for both insured and uninsured patients;
- productivity and quality improvement programs, revenue cycle assessments and optimization recommendations, and The Joint Commission and other preparedness services;
- coding and compliance support, billing assistance, auditing, training, and data management services at every step in the revenue cycle process;
- accounts receivable management, third-party billing and collections; and
- ongoing measurement and monitoring of key revenue cycle metrics.

These revenue cycle management solutions assist hospitals and other health care organizations in improving cash flow, increasing revenue, and advancing physician and patient satisfaction.

Patient Communications and Engagement Services—Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referrals, calls regarding maternity services and other patient inquiries, (2) community education and outreach, (3) scheduling and appointment reminders, and (4) employee recruitment. Conifer also coordinates and implements mail-based marketing programs to keep patients informed of screenings, seminars and other events and services, as well as conducts patient quality and satisfaction surveys to provide valuable feedback to its clients. In addition, Conifer provides clinical admission reviews that are intended to provide evidence-based support for physician decisions on patient status and reduce staffing costs.

Table of Contents

Management Services—Conifer also supports value-based performance through clinical integration, financial risk management and population health management, all of which assist hospitals, physicians, accountable care organizations ("ACOs"), health plans and employers in improving the cost and quality of health care delivery, as well as patient outcomes. Conifer helps clients build clinically integrated networks that provide predictive analytics and quality measures across the care continuum. In addition, Conifer assists clients in improving both the cost and quality of care by aligning and managing financial incentives among health care stakeholders through risk modeling and management for various payment models. Furthermore, Conifer offers clients tools and analytics to improve quality of care and provide care management support of patients with chronic diseases by identifying high-risk patients and monitoring clinical outcomes.

In May 2012, Conifer entered into a 10-year agreement with Catholic Health Initiatives ("CHI") to provide revenue cycle services for over 50 of CHI's hospitals. As part of this agreement, CHI received a minority ownership interest in Conifer. In addition, in late 2012, Conifer acquired (i) an information management and services company with extensive health care data and proprietary technology and (ii) a hospital revenue cycle management business.

We began reporting Conifer as a separate business segment for financial reporting purposes in the three months ended June 30, 2012. The loss of Conifer's key customers, primarily Tenet and CHI, in the future could have a material adverse impact on the segment. Financial and other information about our Conifer business segment is provided in the Consolidated Financial Statements included in this report.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2013 are set forth in the table beginning on page 3. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own nearly all of our medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

Our corporate headquarters are located in Dallas, Texas. In addition, we maintain administrative and regional offices in markets where we operate hospitals and other businesses, including Conifer. We typically lease our office space under operating lease agreements. We believe that all of our properties are suitable for their respective uses and are, in general, adequate for our present needs.

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. In addition, Conifer has sought patent protection for one of its key innovations. Legal standards relating to the validity, enforceability and scope of protection of patents can be uncertain. We do not know whether Conifer's patent application will result in the issuance of a patent or whether the examination process will require us to further narrow our claims. Our patent application may not result in the grant of a patent with the scope of the claims that we seek, if at all, or the scope of the granted claims may not be sufficiently broad to protect our technology. Any patents that may be granted in the future from pending or future applications may be opposed, contested, circumvented, designed around by a third party, or found to be invalid or unenforceable. Third parties may develop technologies that are similar or superior to our proprietary technologies, duplicate or otherwise obtain and use our proprietary technologies, or design around patents owned or licensed by us. Conversely, although we do not believe our technology infringes any patent or other intellectual property right held by a third party, we could be prevented from providing our service offerings and could be subject to significant damage awards if it is found to do so.

We control access to and the use of our application capabilities through a combination of internal and external controls. We also license some of our software through agreements that impose specific restrictions on customers' ability to use the software, such as prohibiting reverse engineering and limiting the use of copies.

We incorporate third-party commercial and, on occasion, open source software products into our technology platform. We employ third-party licensed software in order to simplify our development and maintenance efforts, support our own technology infrastructure or test a new capability.

MEDICAL STAFF AND EMPLOYEES

General—Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations

subject to ultimate oversight by the hospital's local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of hospitals not owned by us. Members of our medical staffs are free to terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. As of December 31, 2013, we owned over 500 physician practices and employed over 1,500 physicians (where permitted by law). However, the overwhelming majority of the physicians who practice at our hospitals are not our employees. Nurses, therapists, lab technicians, facility maintenance workers and the administrative staffs of hospitals normally are our employees. We are subject to federal minimum wage and hour laws and various state labor laws, and maintain a number of different employee benefit plans.

Our operations depend on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no contractual relationship with us. It is essential to our ongoing business that we attract and retain on our medical staffs an appropriate number of quality physicians in the specialties required to support our services. Although we had a net overall gain in physicians added to the medical staffs of legacy Tenet hospitals in each of the last three years, in some of our markets, physician recruitment and retention are still affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance.

Over 40,000 new employees joined Tenet in October 2013 in connection with our acquisition of Vanguard. As of December 31, 2013, we employed over 100,000 employees (of which 27% were part-time employees) in the following categories:

Hospital operations(1)	92,094
Conifer	10,145
Administrative offices	1,472
Total	103,711

(1) Includes employees whose employment related to the operations of our general hospitals, specialty hospitals, critical access hospital, long-term acute care hospital, outpatient centers, physician practices, health plans, accountable care networks and other health care operations.

Union Activity and Labor Relations—As of December 31, 2013, approximately 21% of our employees were represented by various labor unions. These employees — primarily registered nurses and service and maintenance workers — were located at 39 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating an initial contract at one of our hospitals where employees recently chose union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014.

Shortage of Experienced Nurses and Mandatory Nurse-Staffing Ratios— In addition to union activity, factors that adversely affect our labor costs include the nationwide shortage of experienced nurses and the enactment of state laws regarding nurse-staffing ratios. Although our nurse turnover rates are favorable overall, like others in the health care industry, we continue to experience a shortage of seasoned nurses in certain key specialties and geographic areas. Most applicants for our nursing positions are newly licensed nurses rather than experienced nurses, which requires us to make greater investments in education and training. In addition, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. We continually monitor our nurse-staffing ratios in California in an effort to achieve full compliance with the state-mandated nurse-staffing ratios there. Nurse-staffing ratio legislation has been proposed in, but not yet enacted by, Congress and other states besides California in which we operate hospitals, including Florida, Michigan and Pennsylvania. In Texas and Missouri, hospitals are required to adopt, implement and enforce official nurse staffing plans, but are not required to maintain staffing ratios.

COMPETITION

HEALTH CARE SERVICES

Overall, our hospitals, outpatient centers and other health care businesses operate in competitive environments, primarily at the local level. Generally, other hospitals and outpatient centers in the local communities we serve provide services

similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, competing facilities (1) may offer a broader array of services to patients and physicians than ours, (2) may have larger or more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, or (4) may be more centrally located with better parking or closer proximity to public transportation. In the future, we expect to encounter increased competition from companies, like ours, that consolidate hospitals and health care companies in specific geographic markets. Continued consolidation in the health care industry will be a leading factor contributing to greater competition in our current markets and markets we may enter in the future.

We also face increased competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high-margin services and for quality physicians and personnel. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations. These tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. In addition, in certain markets in which we operate, large teaching hospitals provide highly specialized facilities, equipment and services that may not be available at our hospitals.

Another major factor in the competitive position of a hospital or outpatient facility is the ability to negotiate contracts with managed care plans. HMOs, PPOs, third-party administrators, and other third-party payers use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals' established charges. Our future success depends, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care providers may affect our ability to enter into acceptable managed care contractual arrangements or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Furthermore, the trend toward consolidation among non-government payers tends to increase their bargaining power over fee structures. In addition, as various provisions of the Affordable Care Act are implemented, including the establishment of health insurance exchanges, non-government payers may increasingly demand reduced fees or be unwilling to negotiate reimbursement increases.

State laws that require findings of need for construction and expansion of health care facilities or services (as described in "Health Care Regulation and Licensing — Certificate of Need Requirements" below) may also have the effect of restricting competition. In addition, in those states that do not have certificate of need requirements or that do not require review of health care capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

Our strategies are designed to help our hospitals remain competitive. Broadly speaking, we attract physicians by providing high-quality care to our patients and otherwise creating an environment in which physicians prefer to practice. We continue to invest in our *Physician Relationship Program,* which is centered on understanding the needs of physicians who admit patients both to our hospitals and to our competitors' hospitals and responding to those needs with changes and improvements in our hospitals and operations. We have targeted capital spending in order to address specific needs or growth opportunities of our hospitals, which is expected to have a positive impact on their volumes. We have also sought to include all of our hospitals and an increased number of our affiliated physicians in the affected geographic area or nationally when negotiating new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks. In addition, we have completed clinical service line market demand analyses and profitability assessments to determine which services are highly valued that can be emphasized and marketed to improve our operating results. This *Targeted Growth Initiative* ("TGI") has resulted in some reductions in unprofitable service lines in several locations. However, the de-emphasis or elimination of certain unprofitable service lines as a result of our TGI analyses will allow us to dedicate more resources on services that are in higher demand and are more profitable. Moreover, we have increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, as well as increased predictability and efficiency for physicians.

We have also made significant investments in the last decade in equipment, technology, education and operational strategies designed to improve clinical quality at our hospitals and outpatient centers. As a result of our efforts, our CMS Hospital Compare Core Measures scores have consistently exceeded the national average since the end of 2005, and major national private payers have also recognized our achievements relative to quality. These designations are expected to become increasingly important as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others. Through our *Commitment to Quality* and *Performance Excellence Program* initiatives, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using

labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effect of reducing costs, increasing payments from Medicare and certain managed care payers for our services, and increasing physician and patient satisfaction, which may improve our volumes.

Further, each hospital has a local governing board, consisting primarily of community members and physicians, that develops short-term and long-term plans for the hospital to foster a desirable medical environment. Each local governing board also reviews and approves, as appropriate, actions of the medical staff, including staff appointments, credentialing, peer review and quality assurance. While physicians may terminate their association with our hospitals at any time, we believe that by striving to maintain and improve the quality of care at our hospitals and by maintaining ethical and professional standards, we will attract and retain qualified physicians with a variety of specialties.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Our Conifer subsidiary faces competition from existing participants and new entrants to the revenue cycle management market. In addition, the internal revenue cycle management staff of hospitals and other health care providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions sometimes choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, most of which focus on small components of the hospital revenue cycle, including:

- software vendors and other technology-supported revenue cycle management business process outsourcing companies;
- traditional consultants, either specialized health care consulting firms or health care divisions of large accounting firms; and
- large, non-healthcare focused business process and information technology outsourcing firms.

We believe that competition for the revenue cycle management and other services Conifer provides is based primarily on: (1) knowledge and understanding of the complex public and private health care payment and reimbursement systems; (2) a track record of delivering revenue improvements and efficiency gains for hospitals and other health care providers; (3) the ability to deliver solutions that are fully integrated along each step of the revenue cycle; (4) cost-effectiveness, including the breakdown between up-front costs and pay-for-performance incentive compensation; (5) reliability, simplicity and flexibility of the technology platform; (6) understanding of the health care industry's regulatory environment; (7) sufficient infrastructure; and (8) financial stability.

To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

HEALTH CARE REGULATION AND LICENSING

AFFORDABLE CARE ACT

The Affordable Care Act is changing how health care services in the United States are covered, delivered and reimbursed. The primary goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. To fund the expansion of insurance coverage, the legislation contains measures designed to promote quality and cost efficiency in health care delivery and to generate budgetary savings in the Medicare and Medicaid programs. In addition, the Affordable Care Act contains provisions intended to strengthen fraud and abuse enforcement.

Table of Contents

Health Insurance Market Reforms—The Affordable Care Act contains provisions requiring most Americans to maintain, and employers to provide, "minimal essential" health insurance coverage. For individuals who are not exempt from the "individual mandate," and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Health insurance exchanges are government-regulated organizations that provide competitive markets for buying health insurance by offering individuals and small employers a choice of different health plans, certifying plans that participate, and providing information to help consumers better understand their options. Some states operate their own exchanges while others utilize federally facilitated exchanges. The federally run exchanges, and several of the state-run exchanges, have faced operational hurdles and challenges in the initial period of their operation, which could reduce the number of individuals that obtain coverage through the exchanges in the short term. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Also beginning in 2014, those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty.

The "employer mandate" provision of the Affordable Care Act requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. These large employer coverage provisions were originally scheduled to go into effect on January 1, 2014, but were subsequently deferred one year. On February 10, 2014, the requirements of the employer mandate were further delayed such that companies with 50 to 99 employees will now have until January 1, 2016 to provide coverage under the Affordable Care Act, and companies with 100 or more employees must offer insurance to only 70% of full-time workers in 2015, rather than 95%, to avoid fines. Based on the Congressional Budget Office's most recent estimates, we do not believe that the delays in the employer mandate will have a discernible effect on insurance coverage.

The Affordable Care Act also establishes a number of health insurance market reforms, including bans on lifetime limits and pre-existing condition exclusions, new benefit mandates, and increased dependent coverage. Specifically, group health plans and health insurance issuers offering group or individual coverage:

- may not establish lifetime limits or, beginning January 1, 2014, annual limits on the dollar value of benefits;
- may not rescind coverage of an enrollee, except in instances where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact;
- must reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place; and
- must continue to make dependent coverage available to unmarried dependents until age 26 (coverage for the dependents of unmarried adult children is not required) effective for health plan policy years beginning on or after September 23, 2010 (for plans that offer dependent coverage).

We anticipate that health care providers will generally benefit over time from insurance coverage provisions of the Affordable Care Act; however, it is not clear what impact, if any, the increased obligations on managed care and other private payers imposed by the Affordable Care Act will have on commercial managed care volumes and payment rates in the near term.

Public Program Reforms—Prior to the passage of the Affordable Care Act, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The health care reform law expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. The expansion of the Medicaid program (which will be substantially funded by the federal government) in each state requires state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. There is no deadline for a state to undertake expansion and qualify for the enhanced federal funding available under the Affordable Care Act. We cannot provide any assurances as to whether or when the states in which we operate might choose to expand their Medicaid programs or whether those states that do expand their Medicaid programs will continue to offer expanded eligibility in the future.

The Affordable Care Act also provides that the federal government will subsidize states that create non-Medicaid plans called "Basic Health Programs" for residents whose incomes are greater than 133% but less than 200% of the federal poverty level. Approved state plans will be eligible to receive federal funding, however, CMS announced in February 2013 that Basic Health Programs would not be operational until 2015.

Even though the Affordable Care Act expanded Medicaid eligibility, the law also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including:

- negative adjustments to the annual input price index, or "market basket," updates for Medicare's inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and

- reductions to Medicare disproportionate share hospital ("DSH") payments, beginning in federal fiscal year ("FFY") 2014, as the number of uninsured individuals declines. Medicaid DSH cuts were also initially scheduled to begin in FFY 2014, however, a provision in the Bipartisan Budget Act of 2013 delayed these cuts until FFY 2016.

The Affordable Care Act also contains a number of provisions intended to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. For example, the legislation expands payment penalties based on a hospital's rates of certain Medicare-designated hospital-acquired conditions ("HACs"). These HACs, which would normally result in a higher payment for an inpatient hospital discharge, will instead be paid as though the HAC is not present. Effective July 1, 2011, the Affordable Care Act likewise prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Currently, hospitals with excessive readmissions for certain conditions receive reduced Medicare payments for all inpatient admissions. Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will also receive a 1% reduction in Medicare payment rates. Separately, under a Medicare value-based purchasing program that was launched in FFY 2013, hospitals that satisfy certain performance standards receive increased payments for discharges during the following fiscal year. These payments are funded by decreases in payments to all hospitals for inpatient services. For discharges occurring during FFY 2014 and after, the performance standards must assess hospital efficiency, including Medicare spending per beneficiary. In addition, the Affordable Care Act directed CMS to launch a national pilot program to study the use of bundled payments to hospitals, physicians and post-acute care providers relating to a single admission to promote collaboration and alignment on quality and efficiency improvement; implementation of the pilot program is currently ongoing through the Center for Medicare and Medicaid Innovation within CMS, which has the authority to develop and test new payment methodologies designed to improve quality of care and lower costs.

Furthermore, the Affordable Care Act contains provisions relating to recovery audit contractors ("RACs"), which are third-party organizations under contract with CMS that identify underpayments and overpayments under the Medicare program and recoup any overpayments on behalf of the government. The Affordable Care Act expanded the RAC program's scope to include Medicaid claims and required all states to enter into contracts with RACs.

Other Provisions—The Affordable Care Act contains a number of other additional provisions, including provisions relating to the Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments, Section 1877 of the Social Security Act (commonly referred to as the "Stark" law), and qui tam or "whistleblower" actions, each of which is described in detail below, as well as provisions regarding:

- the creation of an Independent Payment Advisory Board that will make recommendations to Congress regarding additional changes to provider payments and other aspects of the nation's health care system; and

- new taxes on manufacturers and distributors of pharmaceuticals and medical devices used by our hospitals, as well as a requirement that manufacturers file annual reports of payments made to physicians.

The Impact of Health Reform on Us—The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either private or public program coverage. Further, the health reform law provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which will create possible sources of additional revenue. However, it is difficult to predict the full impact of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding a number of material factors, including:

- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);

- how many currently uninsured individuals will obtain coverage (either private health insurance or Medicaid) as a result of the Affordable Care Act;

- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that the Affordable Care Act or components of it will be delayed, revised or eliminated as a result of court challenges or actions by Congress.

Furthermore, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. Any reductions to our reimbursement under the Medicare and Medicaid programs by the Affordable Care Act could adversely affect our business and results of operations to the extent such reductions are not offset by increased revenues from providing care to previously uninsured individuals. It is difficult to predict the effect on our revenues resulting from reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are implemented;
- whether future reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the size of the law's annual productivity adjustment to the market basket;
- the amount of the Medicare DSH reductions that will be made commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions commencing in FFY 2016;
- what the losses in revenues, if any, will be from the law's quality initiatives;
- how successful accountable care networks in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for "excessive readmissions."

In addition, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government health care program.

Because of the many variables involved, we are unable to predict the ultimate net effect on us of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and Medicare and Medicaid DSH funding, and

numerous other provisions in the Affordable Care Act that may affect us. Moreover, we are unable to predict the future course of federal, state and local health care regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Anti-Kickback Statute—Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute") prohibit certain business practices and relationships that might affect the provision and cost of health care services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal health care programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program. Moreover, the Affordable Care Act amended the Anti-kickback Statute to provide that knowledge of the law or the intent to violate the law is not required.

Sanctions for violating the Anti-kickback Statute include criminal and civil penalties, as well as fines and possible exclusion from government programs, such as Medicare and Medicaid. In addition, under the Affordable Care Act, submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act ("FCA"). Furthermore, it is a violation of the federal Civil Monetary Penalties Law to offer or transfer anything of value to Medicare or Medicaid beneficiaries that is likely to influence their decision to obtain covered goods or services from one provider or service over another. Many states have statutes similar to the federal Anti-kickback Statute, except that the state statutes usually apply to referrals for services reimbursed by all third-party payers, not just federal programs.

The federal government has also issued regulations that describe some of the conduct and business relationships that are permissible under the Anti-kickback Statute. These regulations are often referred to as the "Safe Harbor" regulations. Currently, there are safe harbors for various activities, including the following: investment interests; space rental; equipment rental; practitioner recruitment; personal services and management contracts; sales of practices; referral services; warranties; discounts; employees; group purchasing organizations; waivers of beneficiary coinsurance and deductible amounts; managed care arrangements; obstetrical malpractice insurance subsidies; investments in group practices; ambulatory surgery centers; and referral agreements for specialty services. The fact that certain conduct or a given business arrangement does not meet a Safe Harbor does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. Rather, such conduct and business arrangements may be subject to increased scrutiny by government enforcement authorities and should be reviewed on a case-by-case basis.

Stark Law—The Stark law generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined "designated health services," such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services. The exceptions to the referral prohibition cover a broad range of common financial relationships. These statutory, and the subsequent regulatory, exceptions are available to protect certain permitted employment relationships, relocation arrangements, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark Law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

The Affordable Care Act also made changes to the "whole hospital" exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in existing physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital has physician ownership and a Medicare provider agreement as of March 23, 2010 (or, for those hospitals under development at the time of the Affordable Care Act's enactment, as of December 31, 2010). A physician-owned hospital that meets these requirements will still be subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for hospitals with a high percentage of Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. The legislation also subjects a physician-owned hospital to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements. As of December 31, 2013, two of our hospitals are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals.

Implications of Fraud and Abuse Laws—Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

We have a variety of financial relationships with physicians who refer patients to our hospitals, and we may sell ownership interests in certain of our other facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

In accordance with our ethics and compliance program, which is described in detail under "Compliance and Ethics" below, we have policies and procedures in place concerning compliance with the Anti-kickback Statute and the Stark law, among others. In addition, our ethics and compliance, law and audit services departments systematically review a substantial number of our arrangements with referral sources to determine the extent to which they comply with our policies and procedures and with the Anti-kickback Statute, the Stark law and similar state statutes. On the one hand, we may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors and exceptions to the fraud and abuse laws described above; as a result, this unwillingness may put us at a competitive disadvantage. On the other hand, we cannot assure you that the regulatory authorities that enforce these laws will not determine that some of our arrangements violate the Anti-Kickback Statute, the Stark law or other applicable regulations. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that we have violated any of these laws could give Conifer's customers the right to terminate our services agreements with them. Moreover, any violations by and resulting penalties or exclusions imposed upon Conifer's customers could adversely affect their financial condition and, in turn, have a material adverse effect on Conifer's business and results of operations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Title II, Subtitle F of the Health Insurance Portability and Accountability Act mandates the adoption of specific standards for electronic transactions and code sets that are used to transmit certain types of health information. HIPAA's objective is to encourage efficiency and reduce the cost of operations within the health care industry. To protect the information transmitted using the mandated standards and the patient information used in the daily operations of a covered entity, HIPAA also sets forth federal rules protecting the privacy and security of protected health information ("PHI"). The privacy and security regulations address the use and disclosure of individually identifiable health information and the rights of patients to understand and control how their information is used and disclosed. The law provides both criminal and civil fines and penalties for covered entities that fail to comply with HIPAA.

Table of Contents

To receive reimbursement from CMS for electronic claims, health care providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain health care information electronically. Our electronic data transmissions are compliant with current standards. In January 2009, CMS published a final rule changing the formats used for certain electronic transactions and requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. At this time, use of the ICD-10 code sets is not mandatory until October 1, 2014. We are continuing to modify our payment systems and processes to prepare for ICD-10 implementation. Although use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial condition, results of operations or revenues. However, we may experience a short-term adverse impact on our cash flows due to claims processing delays related to payer implementation of the new code sets. Furthermore, the Affordable Care Act requires the U.S. Department of Health and Human Services ("HHS") to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

Under HIPAA, covered entities must establish administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic PHI maintained or transmitted by them or by others on their behalf. The covered entities we operate are in material compliance with the privacy, security and National Provider Identifier requirements of HIPAA. In addition, most of Conifer's customers are covered entities, and Conifer is a business associate to many of those customers under HIPAA as a result of its contractual obligations to perform certain functions on behalf of and provide certain services to those customers. As a business associate, Conifer's use and disclosure of PHI is restricted by HIPAA and the business associate agreements Conifer is required to enter into with its covered entity customers.

In 2009, HIPAA was amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act to impose certain of the HIPAA privacy and security requirements directly upon business associates of covered entities and significantly increase the monetary penalties for violations of HIPAA. Regulations that took effect in late 2009 also require business associates such as Conifer to notify covered entities, who in turn must notify affected individuals and government authorities, of data security breaches involving unsecured PHI. Since the passage of the HITECH Act, enforcement of HIPAA violations has increased. A knowing breach of the HIPAA privacy and security requirements made applicable to business associates by the HITECH Act could expose Conifer to criminal liability, and a breach of safeguards and processes that is not due to reasonable cause or involves willful neglect could expose Conifer to significant civil penalties and the possibility of civil litigation under HIPAA and applicable state law.

In May 2011, the Office for Civil Rights of HHS proposed new regulations to implement changes to the HIPAA requirements set forth in the HITECH Act that state that covered entities and business associates must account for disclosures of PHI to carry out treatment, payment and health care operations if such disclosures are through an electronic health record. The proposed regulations seek to expand the scope of the requirements under the HITECH Act and create a new patient right to an "access report," which would be required to list every person who has accessed, for any reason, PHI about the individual contained in any electronic designated record set. Because our hospitals currently utilize multiple, independent modules that may meet the definition of "electronic designated record set," our ability to produce an access report that satisfies the proposed regulatory requirements would likely require new technology solutions to map across those multiple record sets. It is our understanding that many providers have expressed significant concerns to CMS regarding the access report requirement created by the proposed rule. On January 17, 2013, HHS issued final regulations modifying the requirements set forth in the HITECH Act. While we were in material compliance with the new regulations as of the compliance date of September 23, 2013, the new regulations did not address the proposed "access report" requirement. Because we cannot predict the requirements of any future final rule regarding access reports, we are unable to estimate the costs of compliance, if any, at this time.

We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA, and similar state privacy laws, under the guidance of our ethics and compliance department. Hospital and Conifer compliance officers and information security officers are responsible for implementing and monitoring compliance with our HIPAA privacy and security policies and procedures at our hospitals and Conifer. We have also created an internal web-based HIPAA training program, which is mandatory for all employees. Based on existing regulations and our experience with HIPAA to this point, we continue to believe that the ongoing costs of complying with HIPAA will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

HEALTH PLAN REGULATORY MATTERS

Our health plans are subject to state and federal laws and regulations. CMS has the right to audit our Medicare Advantage and dual-eligible health plans to determine the plans' compliance with CMS regulations and guidelines. In addition, each plan must submit periodic filings to and respond to inquiries and audits by its respective state insurance regulators.

Table of Contents

Furthermore, our health plans are typically required to file periodic reports with their respective state Medicaid agencies, meet certain financial viability standards, provide their members with certain mandated benefits, and meet certain quality assurance and improvement requirements. Our health plans must also comply with the standardized formats for electronic transmissions and the privacy and security standards of HIPAA. We believe our health plans have implemented the necessary policies and procedures to comply with the final federal regulations on these matters and were in compliance with them by their deadlines.

As described above, the Anti-kickback Statute prohibits the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal health program patients or any item or service that is reimbursed, in whole or in part, by any federal health care program. The Safe Harbor regulations that specifically relate to managed care include:

- waivers by HMOs of Medicare and Medicaid beneficiaries' obligations to pay cost-sharing amounts or to provide other incentives in order to attract Medicare and Medicaid enrollees;
- certain discounts offered to prepaid health plans by contracting providers;
- certain price reductions offered to eligible managed care organizations; and
- certain price reductions offered by contractors with substantial financial risk to managed care providers.

We believe that our health plans' arrangements comply in all material respects with the federal Anti-kickback Statute and similar state statutes, and we further believe that the incentives offered by our health plans to their members and the discounts they receive contracting with health care providers satisfy the requirements of the Safe Harbor regulations.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the health care industry. The operational mission of the Office of Inspector General ("OIG") of HHS is to protect the integrity of the Medicare and Medicaid programs and the well-being of program beneficiaries by: detecting and preventing waste, fraud and abuse; identifying opportunities to improve program economy, efficiency and effectiveness; and holding accountable those who do not meet program requirements or who violate federal laws. The OIG carries out its mission by conducting audits, evaluations and investigations and, when appropriate, imposing civil monetary penalties, assessments and administrative sanctions. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with the laws, rules and regulations affecting the health care industry, if a determination is made that we were in material violation of such laws, rules or regulations, our business, financial condition, results of operations or cash flows could be materially adversely affected.

Health care providers are also subject to qui tam or "whistleblower" lawsuits under the federal False Claims Act, which allows private individuals to bring actions on behalf of the government, alleging that a hospital or health care provider has defrauded a government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Affordable Care Act, the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, constitutes a violation of the FCA. Further, the Affordable Care Act expands the scope of the FCA to cover payments in connection with health insurance exchanges if those payments include any federal funds. Qui tam actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies. Like other companies in the health care industry, we are subject to qui tam actions from time to time. We are unable to predict the future impact of such actions on our business, financial condition, results of operations or cash flows.

Table of Contents

HEALTH CARE FACILITY LICENSING REQUIREMENTS

The operation of health care facilities is subject to federal, state and local regulations relating to personnel, operating policies and procedures, fire prevention, rate-setting, the adequacy of medical care, and compliance with building codes and environmental protection laws. Various licenses and permits also are required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our health care facilities hold all required governmental approvals, licenses and permits material to the operation of their business.

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

In addition to certain statutory coverage limits and exclusions, federal laws and regulations, specifically the Medicare Conditions of Participation, generally require health care providers, including hospitals that furnish or order health care services that may be paid for under the Medicare program or state health care programs, to ensure that claims for reimbursement are for services or items that are (1) provided economically and only when, and to the extent, they are medically reasonable and necessary, (2) of a quality that meets professionally recognized standards of health care, and (3) supported by appropriate evidence of medical necessity and quality. The Social Security Act established the Utilization and Quality Control Peer Review Organization program, now known as the Quality Improvement Organization ("QIO") program, to promote the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. CMS administers the program through a network of QIOs that work with consumers, physicians, hospitals and other caregivers to refine care delivery systems to ensure patients receive the appropriate care at the appropriate time, particularly among underserved populations. The QIO program also safeguards the integrity of the Medicare trust fund by reviewing Medicare patient admissions, treatments and discharges, and ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care. The QIOs have the authority to deny payment for services provided and recommend to HHS that a provider that is in substantial noncompliance with certain standards be excluded from participating in the Medicare program.

There has been recent increased scrutiny of hospitals' Medicare observation rates from outside auditors, government enforcement agencies and industry observers. The term "Medicare observation rate" is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In our affiliated hospitals, we use the independent, evidence-based clinical criteria developed by McKesson Corporation, commonly known as InterQual Criteria, to determine whether a patient qualifies for inpatient admission. The industry anticipates increased scrutiny and litigation risk, including government investigations and qui tam suits, related to inpatient admission decisions and the Medicare observation rate. In addition, effective October 1, 2013, CMS established a new concept, referred to as the "two-midnight rule," to guide practitioners admitting patients and contractors conducting payment reviews on when it is appropriate to admit individuals as hospital inpatients. Under the two-midnight rule, CMS has indicated that a Medicare patient should generally be admitted on an inpatient basis only when there is a reasonable expectation that the patient's care will cross two midnights, and, if not, then the patient generally should be treated as an outpatient. Our hospitals have undertaken extensive efforts to implement the two-midnight rule in light of existing guidance. CMS is currently conducting a "probe and educate" program regarding the two-midnight rule, the purpose of which is to assess hospitals' compliance with the rule and also to provide follow-up education. The probe and educate period is currently scheduled to end September 30, 2014 and, unless extended, full implementation and enforcement of the two-midnight rule will begin on October 1, 2014. Because of the newness of the two-midnight rule, and the fact that the probe and educate program is ongoing, it is unclear what impact, if any, the two-midnight rule will have on inpatient admission rates at our hospitals.

Medical and surgical services and practices are extensively supervised by committees of staff doctors at each of our health care facilities, are overseen by each facility's local governing board, the members of which primarily are community members and physicians, and are reviewed by our clinical quality personnel. The local hospital governing board also helps maintain standards for quality care, develop short-term and long-range plans, and establish, review and enforce practices and procedures, as well as approves the credentials, disciplining and, if necessary, the termination of privileges of medical staff members.

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of health care facilities, including findings of need for additional or expanded health care facilities or services. Certificates or determinations of need, which are issued by

governmental agencies with jurisdiction over health care facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. As of December 31, 2013, we operated hospitals in 10 states that require a form of state approval under certificate of need programs applicable to those hospitals. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license. We are unable to predict whether we will be required or able to obtain any additional certificates of need in any jurisdiction where they are required, or if any jurisdiction will eliminate or alter its certificate of need requirements in a manner that will increase competition and, thereby, affect our competitive position. In those states that do not have certificate of need requirements or that do not require review of health care capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

ENVIRONMENTAL MATTERS

Our health care operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with laws and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws and regulations, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows.

Consistent with our commitment to meet the highest standards of corporate responsibility, we have formed a sustainability committee consisting of corporate and hospital leaders to regularly evaluate our environmental outcomes and share best practices among our hospitals and other facilities. In 2013, we published our third annual sustainability report, using the industry-standard Global Reporting Initiative framework. In addition, we are a sponsor of the *Healthier Hospitals Initiative* and continue to work with each of our hospitals in adopting components of the initiative's agenda, which focuses on improvements in (1) sustainability governance, (2) the provision of healthier foods, (3) energy consumption, (4) waste generation, (5) the use of safer chemicals and (6) purchasing decisions. We are committed to report the results of our sustainability efforts on an annual basis.

ANTITRUST LAWS

The federal government and most states have enacted antitrust laws that prohibit specific types of anti-competitive conduct, including price fixing, wage fixing, concerted refusals to deal, price discrimination and tying arrangements, as well as monopolization and acquisitions of competitors that have, or may have, a substantial adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties.

Antitrust enforcement in the health care industry is currently a priority of the U.S. Federal Trade Commission ("FTC"). In recent years, the FTC has filed multiple administrative complaints challenging hospital transactions in several states. The FTC has focused its enforcement efforts on preventing hospital mergers that may, in the government's view, leave insufficient local options for inpatient services. In addition to hospital merger enforcement, the FTC has given increased attention to the effect of combinations involving other health care providers, including physician practices. The FTC has also entered into numerous consent decrees in the past several years settling allegations of price-fixing among providers.

We believe we are in compliance with federal and state antitrust laws, but there can be no assurance that a review of our practices by courts or regulatory authorities would not result in a determination that could adversely affect our operations.

REGULATIONS AFFECTING CONIFER

DEBT COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act ("FDCPA") regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable

Table of Contents

handled by Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC ("SOS"), are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. Further, the FDCPA prohibits harassment or abuse by debt collectors, including the threat of violence or criminal prosecution, obscene language or repeated telephone calls made with the intent to abuse or harass. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt and sets forth specific procedures to be followed when communicating with such third parties for purposes of obtaining location information about the consumer. In addition, the FDCPA contains various notice and disclosure requirements and prohibits unfair or misleading representations by debt collectors. Finally, the FDCPA imposes certain limitations on lawsuits to collect debts against consumers. Debt collection activities are also regulated at the state level. Most states have laws regulating debt collection activities in ways that are similar to, and in some cases more stringent than, the FDCPA.

In certain situations, the activities of SOS are also subject to the Fair Credit Reporting Act ("FCRA"), which regulates consumer credit reporting and which may impose liability on us to the extent that adverse credit information reported on a consumer to a credit bureau is false or inaccurate. State law, to the extent it is not preempted by the FCRA, may also impose restrictions or liability on us with respect to reporting adverse credit information that is false or inaccurate.

The U.S. Consumer Financial Protection Bureau ("CFPB") and the FTC have the authority to investigate consumer complaints relating to the FDCPA and the FCRA, and to initiate enforcement actions, including actions to seek restitution and monetary penalties. State officials typically have authority to enforce corresponding state laws. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

The CFPB was formed within the U.S. Federal Reserve pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act") to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. In 2013, the CFPB issued examination procedures for, and began conducting examinations of, a number of companies with respect to their debt collection practices. The CFPB's examination authority permits agency examiners to inspect the books and records of companies engaged in debt collection activities, such as SOS, and ask questions about their payment processing activities, collections, accounts in default, consumer reporting and third-party relationships, as well as compliance programs. We believe that the potential exists that non-bank providers of consumer credit that are examined by the CFPB could, depending upon the circumstances, be required, as a result of any CFPB examination, to change their practices or procedures. In August 2013, Conifer received a civil investigative demand from the CFPB that requires Conifer to provide to the CFPB a broad range of information regarding its debt collection activities, including its internal compliance procedures. To date, the CFPB has not indicated that it has targeted any particular issue or concern underlying the issuance of the civil investigative demand. Conifer is cooperating with the CFPB in providing the requested information.

CREDIT CARD ACTIVITIES

Conifer accepts credit card payments from patients of its facilities. Various federal and state laws and regulations impose privacy and information security standards with respect to the acceptance of credit cards as a form of payment. If Conifer fails to comply with these laws and regulations or experiences a credit card security breach, its reputation could be damaged, possibly resulting in lost business, and it could be subjected to additional legal or financial risk as a result of non-compliance.

COMPLIANCE AND ETHICS

General—Our ethics and compliance department maintains our multi-faceted, values-based ethics and compliance program, which is designed to (1) help staff in our corporate and Conifer offices, hospitals, outpatient centers, health plan offices and physician practices meet or exceed applicable standards established by federal and state laws and regulations, as well as industry practice, and (2) monitor and raise awareness of ethical issues among employees and others, and stress the importance of understanding and complying with our *Standards of Conduct*. The ethics and compliance department operates with independence — it has its own operating budget; it has the authority to hire outside counsel, access any Tenet document and interview any of our personnel; and our chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

Table of Contents

Program Charter—In September 2011, the quality, compliance and ethics committee of our board of directors approved an updated Q *uality, Compliance and Ethics Program Charter* intended to:

- support and maintain our present and future responsibilities with regard to participation in federal health care programs; and
- further our goals of (1) fostering and maintaining the highest ethical standards among all employees, officers and directors, physicians practicing at Tenet facilities and contractors that furnish health care items or services, and (2) valuing our compliance with all state and federal laws and regulations as a foundation of our corporate philosophy.

The primary focus of our quality, compliance and ethics program is compliance with the requirements of Medicare, Medicaid and other federally funded health care programs. Pursuant to the terms of the charter, our ethics and compliance department is responsible for the following activities: (1) annually assessing, critiquing and (as appropriate) drafting and distributing company policies and procedures; (2) developing, providing and tracking ethics training for all employees, directors and, as applicable, contractors and agents; (3) developing, providing and tracking job-specific training to those who work in clinical quality, coding, billing, cost reporting and referral source arrangements; (4) developing, providing and tracking annual training on ethics and clinical quality oversight to the members of each hospital governing board; (5) creating and disseminating the company's *Standards of Conduct* and obtaining certifications of adherence to the *Standards of Conduct* as a condition of employment; (6) maintaining and promoting Tenet's Ethics Action Line, which allows confidential reporting of issues on an anonymous basis and emphasizes Tenet's no retaliation policy; (7) responding to and resolving all compliance-related issues that arise from the Ethics Action Line and compliance reports received from our facilities, hospital compliance officers or any other source; (8) ensuring that appropriate corrective and disciplinary actions are taken when non-compliant conduct or improper contractual relationships are identified; (9) monitoring and measuring adherence to all applicable Tenet policies and legal and regulatory requirements related to federal health care programs; (10) directing an annual screening of individuals for exclusion from federal health care program participation as required by federal regulations; (11) maintaining a database of all arrangements involving the payment of anything of value between Tenet and any physician or other actual or potential source of health care business or referrals to or from Tenet; and (12) overseeing annual audits of clinical quality, referral source arrangements, outliers, charging, coding, billing and other compliance risk areas as may be identified from time to time.

Standards of Conduct—All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Standards of Conduct* to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and many of our contractors are also required to abide by our *Standards of Conduct*. The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable laws and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

As part of the program, we provide annual training sessions to every employee, as well as our board of directors and certain physicians and contractors. All employees are required to report incidents that they believe in good faith may be in violation of the *Standards of Conduct*, and are encouraged to contact our 24-hour toll-free Ethics Action Line when they have questions about the standards or any ethics concerns. All reports to the Ethics Action Line are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. Incidents of alleged financial improprieties reported to the Ethics Action Line or the ethics and compliance department are communicated to the audit committee of our board of directors. Reported cases that involve a possible violation of the law or regulatory policies and procedures are referred to the ethics and compliance department for investigation. Retaliation against employees in connection with reporting ethical concerns is considered a serious violation of our *Standards of Conduct*, and, if it occurs, it will result in discipline, up to and including termination of employment.

Availability of Documents—The full text of our *Quality, Compliance and Ethics Program Charter,* our *Standards of Conduct*, and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the "Ethics and Compliance" caption in the "About" section. A copy of our *Standards of Conduct* is also available upon written request to our corporate secretary. Information about how to contact our corporate secretary is set forth under "Company Information" below. Amendments to the *Standards of Conduct* and any grant of a waiver from a provision of the *Standards of Conduct* requiring disclosure under applicable Securities and Exchange Commission ("SEC") rules will be disclosed at the same location as the *Standards of Conduct* on our website.

Table of Contents

INSURANCE

Property Insurance—We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Insurance—As is typical in the health care industry, we are subject to claims and lawsuits in the ordinary course of business. The health care industry has seen significant increases in the cost of professional liability insurance due to increased litigation. In response, we formed and maintain captive insurance companies to self-insure a substantial portion of our professional and general liability risk. We also own two captive insurance companies that write professional liability insurance for a small number of physicians, including employed physicians, who are on the medical staffs of certain of our hospitals.

Claims in excess of our self-insurance retentions are insured with commercial insurance companies. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital.

In addition to the reserves recorded by our captive insurance subsidiaries, we maintain reserves, including reserves for incurred but not reported claims, for our self-insured professional liability retentions and claims in excess of the policies' aggregate limits, based on actuarial estimates of losses and related expenses. Also, we provide standby letters of credit to certain of our insurers, which can be drawn upon under certain circumstances, to collateralize the deductible and self-insured retentions under a selected number of our professional and general liability insurance programs.

COMPANY INFORMATION

Tenet Healthcare Corporation was incorporated in the State of Nevada in 1975. We file annual, quarterly and current reports, proxy statements and other documents with the SEC under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Our reports, proxy statements and other documents filed electronically with the SEC are available at the website maintained by the SEC at www.sec.gov.

Our website, www.tenethealth.com, also offers, free of charge, access to our annual, quarterly and current reports (and amendments to such reports), and other filings made with, or furnished to, the SEC as soon as reasonably practicable after such documents are submitted to the SEC. The information found on our website is not part of this or any other report we file with or furnish to the SEC.

Inquiries directed to our corporate secretary may be sent to Corporate Secretary, Tenet Healthcare Corporation, P.O. Box 139003, Dallas, Texas 75313-9003 or by e-mail at CorporateSecretary@tenethealth.com.

FORWARD-LOOKING STATEMENTS

The information in this report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. These forward-looking statements represent management's current belief, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors — many of which we are unable to predict or control — that may cause our actual results, performance or achievements, or health care industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the following:

- The impact of the Affordable Care Act on our business and the enactment of, or changes in, laws and regulations affecting the health care industry generally;

- The effect that adverse economic conditions have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things;

Table of Contents

- Adverse litigation or regulatory developments;
- Our ability to enter into managed care provider arrangements on acceptable terms;
- Cuts to Medicare and Medicaid payment rates or changes in reimbursement practices;
- Competition;
- Our success in implementing our business development plans;
- Our ability to hire and retain qualified personnel, especially health care professionals;
- The availability and terms of capital to fund the expansion of our business, including the acquisition of additional facilities;
- Our success in marketing Conifer's revenue cycle management, health care information management, management services, and patient communications and engagement services to third-party hospitals and other healthcare-related entities;
- Our ability to realize fully or at all the anticipated benefits of our acquisition of Vanguard and to successfully integrate the operations of our business and Vanguard's business;
- Our ability to identify and execute on measures designed to save or control costs or streamline operations;
- The impact of our significant indebtedness; and
- Other factors and risks referenced in this report and our other public filings.

Also included among the foregoing factors are the positive and negative effects of health reform legislation on reimbursement and utilization, as well as the future design of provider networks and insurance plans, including pricing, provider participation, coverage, and co-pays and deductibles.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in this report. Should one or more of the risks and uncertainties described in this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statements. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

All forward-looking statements attributable to us are expressly qualified in their entirety by this cautionary statement.

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties — many of which are beyond our control — that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in the following risks were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment.

We cannot predict with certainty the ultimate net effect that the Affordable Care Act may have on our business, financial condition, results of operations or cash flows.

The Affordable Care Act is changing how health care services in the United States are covered, delivered and reimbursed. The expansion of health insurance coverage under the law may result in a material increase in the number of patients using our facilities who have either private or public program coverage. However, it is difficult to predict the full impact of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding a number of material factors, including:

- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);
- how many currently uninsured individuals will obtain coverage (either private health insurance or Medicaid) as a result of the Affordable Care Act;
- what percentage of the newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the rate paid to hospitals by private payers for newly covered individuals, including those covered through the newly created exchanges and those who might be covered under the Medicaid program under contracts with the state;
- the rate paid by state governments under the Medicaid program for newly covered individuals;
- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals;
- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business; and
- the possibility that the Affordable Care Act or components of it will be delayed, revised or eliminated as a result of court challenges or actions by Congress.

Furthermore, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. A substantial portion of both our patient volumes and, as result, our revenues is derived from government health care programs, principally Medicare and Medicaid. Any reductions to our reimbursement under the Medicare and Medicaid programs by the Affordable Care Act could adversely affect our business and results of operations to the extent such reductions are not offset by increased revenues from providing care to previously uninsured individuals. It is difficult to predict the effect on our revenues resulting from reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are implemented;
- whether future reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the size of the law's annual productivity adjustment to the market basket;
- the amount of the Medicare DSH reductions that will be made commencing in FFY 2014;
- the allocation to our hospitals of the Medicaid DSH reductions commencing in FFY 2016;
- what the losses in revenues, if any, will be from the law's quality initiatives;
- how successful accountable care networks in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and

- reductions to Medicare payments CMS may impose for "excessive readmissions."

In addition, the federally run exchanges, and several of the state-run exchanges, have faced operational hurdles and challenges in the initial period of their operation, which could reduce the number of individuals that obtain coverage through the exchanges in the short term. Further, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government health care program.

In general, there is significant uncertainty with respect to the positive and negative effects the Affordable Care Act may have on reimbursement, utilization and the future design of provider networks and insurance plans (including pricing, provider participation, coverage, co-pays and deductibles), and the multiple models that attempt to predict those effects may differ materially from our expectations. Because of the many variables involved, we are unable to predict the ultimate net effect on us of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Moreover, we are unable to predict the future course of federal, state and local health care regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

If we are unable to enter into and maintain managed care contractual arrangements on acceptable terms, if we experience material reductions in the contracted rates we receive from managed care payers or if we have difficulty collecting from managed care payers, our results of operations could be adversely affected.

We currently have thousands of managed care contracts with various HMOs and PPOs. The amount of our managed care net patient revenues during the year ended December 31, 2013 was $6.3 billion, which represented approximately 58% of our total net patient revenues before provision for doubtful accounts. Approximately 59% of our managed care net patient revenues for the year ended December 31, 2013 was derived from our top ten managed care payers. In the year ended December 31, 2013, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. In addition, at December 31, 2013, approximately 58% of our net accounts receivable related to continuing operations were due from managed care payers.

Our ability to negotiate favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. In addition, private payers are increasingly attempting to control health care costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. The trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. It is not clear what impact, if any, the increased obligations on private payers imposed by the health care reform law will have on our ability to negotiate reimbursement increases. However, as various provisions of the Affordable Care Act are implemented, including the establishment of the exchanges, non-government payers may increasingly demand reduced fees. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other health care companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services, coupled with any difficulties in collecting receivables from managed care payers, could have a material adverse effect on our financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from private payers could be exacerbated if we are not able to manage our operating costs effectively.

Further changes in the Medicare and Medicaid programs or other government health care programs could have an adverse effect on our business.

For the year ended December 31, 2013, approximately 22% of our net patient revenues before provision for doubtful accounts for our general hospitals were related to the Medicare program, and approximately 9% of our net patient revenues before provision for doubtful accounts for our general hospitals were related to various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. In addition to the changes affected by the Affordable Care Act, the Medicare and Medicaid programs are subject to: other statutory and regulatory changes, administrative rulings, interpretations

and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from government programs could be exacerbated if we are not able to manage our operating costs effectively.

Several states in which we operate continue to face budgetary challenges due to the economic downturn and other factors that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce their Medicaid expenditures. In addition, some states are implementing delays in issuing Medicaid payments to providers. As an alternative means of funding provider payments, most of the states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

In general, we are unable to predict the effect of future government health care funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government health care program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

The industry trend toward value-based purchasing may negatively impact our revenues.

We believe that value-based purchasing initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other health care facilities and may negatively impact our revenues if we are unable to meet expected quality standards. The Affordable Care Act contains a number of provisions intended to promote value-based purchasing in federal health care programs. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions, also known as HACs, unless the conditions were present at admission. Beginning in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year will receive reduced Medicare reimbursements. The Affordable Care Act also prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

There is a trend among private payers toward value-based purchasing of health care services, as well. Many large commercial payers require hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues if we are unable to meet quality standards established by both governmental and private payers.

Our business continues to be adversely affected by a high volume of uninsured and underinsured patients, as well as declines in commercial managed care patients.

Like other organizations in the health care industry, we continue to provide services to a high volume of uninsured patients and more patients than in prior years with increased burdens of co-pays and deductibles due to changes in their health care plans. As a result, we continue to experience a high level of uncollectible accounts, and, unless our business mix shifts toward a greater number of insured patients as a result of the Affordable Care Act or otherwise, the trend of higher co-pays and deductibles reverses, or the economy improves and unemployment rates decline, we anticipate this high level of uncollectible accounts to continue or increase. In addition, even after implementation of the Affordable Care Act, we may continue to experience significant levels of bad debt expense and have to provide uninsured discounts and charity care for undocumented aliens who are not permitted to enroll in a health insurance exchange or government health care program.

Over the past several years, we have experienced declines in our commercial managed care volumes, which in the aggregate generate substantially higher yields than Medicare and Medicaid volumes. The declines in our commercial managed

care volumes are due, in part, to the related effects of higher unemployment and reductions in commercial managed care enrollment. In addition, we believe that the growth in high-deductible health plans has adversely impacted commercial managed care volumes.

Our hospitals, outpatient centers and other health care businesses operate in competitive environments, and competition is one reason increases in patient volumes have been constrained.

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities (1) are more established or newer than ours, (2) may offer a broader array of services to patients and physicians than ours, and (3) may have larger or more specialized medical staffs to admit and refer patients, among other things. Furthermore, health care consumers are now able to access hospital performance data on quality measures and patient satisfaction, as well as standard charges for services, to compare competing providers; if any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or patient satisfaction surveys, or if our standard charges are higher than our competitors, we may attract fewer patients. Additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

Continued consolidation in the health care industry will be a leading factor contributing to greater competition in our current markets and markets we may enter in the future. We also face increased competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high margin services and for quality physicians and personnel. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. As is the case with our hospitals, some of our health plan competitors are owned by governmental agencies or non-profit corporations that have greater financial resources than we do. If our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than we are, we may experience an overall decline in patient volumes

We could be subject to substantial uninsured liabilities or increased insurance costs as a result of significant legal actions.

We are subject to medical malpractice lawsuits, class action lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to such caps. Our professional and general liability insurance does not cover all claims against us, and it may not continue to be available at a reasonable cost for us to maintain at adequate levels, as the health care industry has seen significant increases in the cost of such insurance due to increased litigation. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

If we are unable to recruit and retain an appropriate number of quality physicians on the medical staffs of our hospitals, our business may suffer.

The success of our business depends in significant part on the number, quality and specialties of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and maintaining good relations with those physicians. Although we operate physician practices and, where permitted by law, employ physicians, physicians are often not employees of the hospitals at which they practice and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. Such physicians may terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment and hospital facilities that meet the

needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

Our labor costs could be adversely affected by competition for staffing, the shortage of experienced nurses and labor union activity.

Our hospital operations depend on the efforts, abilities and experience of our management and medical support personnel, including nurses, pharmacists and lab technicians, as well as our employed physicians. We compete with other health care providers in recruiting and retaining physicians and qualified management responsible for the daily operations of our hospitals. In addition, like others in the health care industry, we continue to experience a shortage of seasoned nurses in certain key specialties and geographic areas. As a result, from time to time, we may be required to enhance wages and benefits to recruit and retain experienced nurses, make greater investments in education and training for newly licensed nurses, or hire more expensive temporary or contract personnel. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit patient admissions with a corresponding adverse effect on our net operating revenues. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Increased labor union activity is another factor that could adversely affect our labor costs. At December 31, 2013, approximately 21% of our employees were represented by various labor unions. These employees — primarily registered nurses and service and maintenance workers — were located at 39 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating an initial contract at one of our hospitals where employees recently chose union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014; to the extent a greater portion of our employee base unionizes, it is possible our labor costs could increase materially.

Conifer's future success also depends in part on our ability to attract, hire, integrate and retain key personnel. Competition for the caliber and number of employees we require at Conifer is intense. We may face difficulty identifying and hiring qualified personnel at compensation levels consistent with our existing compensation and salary structure. In addition, we invest significant time and expense in training Conifer's employees, which increases their value to competitors who may seek to recruit them. If we fail to retain our Conifer employees, we could incur significant expenses in hiring, integrating and training their replacements, and the quality of Conifer's services and its ability to serve its customers could diminish, resulting in a material adverse effect on that segment of our business.

Our business and financial results could be harmed by violations of existing regulations or compliance with new or changed regulations.

Our business is subject to extensive federal, state and local regulation relating to, among other things, licensure, conduct of operations, privacy of patient information, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the health care industry are extremely complex and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. If a determination is made that we were in violation of such laws, rules or regulations, we could be subject to penalties or liabilities or required to make significant changes to our operations. In addition, Conifer's failure to comply with the laws and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its customers, or give customers the right to terminate Conifer's services agreements with them, among other things, any of which could have an adverse effect on Conifer's business. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on the value of our common stock and our business reputation could suffer. Furthermore, health care, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively affecting health care providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We are also required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

Conifer operates in a highly competitive industry, and its current or future competitors may be able to compete more effectively than Conifer does, which could have a material adverse effect on Conifer's business, revenue, growth rate and market share.

We intend to continue expanding Conifer's revenue cycle management, patient communications and engagement services, and management services businesses by marketing these services to non-Tenet hospitals and other healthcare-related entities. However, the market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market (including software vendors and other technology-supported revenue cycle management outsourcing companies, traditional consultants and information technology outsourcing firms), as well as from the internal staffs of hospitals and other health care providers who, as described above, handle these processes internally. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Moreover, existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

The failure to comply with debt collection and consumer credit reporting regulations could subject Conifer's SOS subsidiary to fines and other liabilities, which could harm Conifer's reputation and business, and could make it more difficult for Conifer to retain existing customers or attract new customers.

The Fair Debt Collection Practices Act regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by SOS, Conifer's debt collection agency subsidiary, are subject to the FDCPA. Many states impose additional requirements on debt collection communications, and some of those requirements may be more stringent than the federal requirements. Moreover, regulations governing debt collection are subject to changing interpretations that may be inconsistent among different jurisdictions. SOS could be subject to fines or other penalties if it is determined to have violated the FDCPA, the Fair Credit Reporting Act or analogous state laws, which could make it more difficult to retain existing customers or attract new customers and could otherwise harm Conifer's business.

Our business could be negatively affected by security threats, catastrophic events and other disruptions affecting our information technology and related systems.

As a provider of health care services, we rely on our information technology in the day-to-day operation of our business to process, transmit and store sensitive or confidential data, including electronic health records, other protected health information, and financial, payment and other personal data of patients, as well as to store our proprietary and confidential business performance data. We utilize a diversified data and voice network, along with technology systems for billing, supply chain, clinical information systems and labor management. Although we have redundancies and other measures designed to protect the security and availability of the data we process, transmit and store, our information technology and infrastructure is vulnerable to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. Furthermore, our networks and technology systems are subject to disruption due to events such as a major earthquake, fire, telecommunications failure, terrorist attack or other catastrophic event. Any such breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact our ability to conduct normal business operations (including the collection of revenues), and could result in potential liability and damage to our reputation, any of which could have a material adverse effect on our business, financial position, results of operations or cash flows.

Economic downturns and other economic factors have affected, and may continue to impact, our business, financial condition and results of operations.

We continue to be impacted by a number of industry-wide challenges, including constrained growth in patient volumes and high levels of bad debt expense. We believe factors associated with the recent economic downturn — including higher levels of unemployment, reductions in commercial managed care enrollment, and patient decisions to postpone or cancel elective and non-emergency health care procedures — have affected our volumes and our ability to collect outstanding receivables. The U.S. economy remains volatile. Instability in consumer spending and high unemployment rates continue to pressure many industries.

Table of Contents

If industry trends or general economic conditions worsen, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Furthermore, the availability of liquidity and credit to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, to access those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions, and our ability to refinance existing debt. The economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under our senior secured revolving credit facility, causing them to fail to meet their obligations to us.

Trends affecting our actual or anticipated results may require us to record charges that would adversely affect our results of operations.

As a result of factors that have negatively affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospitals' most recent projections. If these projections are not met, or negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges. Future restructuring of our operating structure that changes our goodwill reporting units could also result in future impairments of our goodwill. Any such charges could adversely affect our results of operations.

The amount and terms of our current and any future debt could, among other things, adversely affect our ability to raise additional capital to fund our operations and limit our ability to react to changes in the economy or our industry.

As of December 31, 2013, we had approximately $10.8 billion of total long-term debt, as well as approximately $189 million in standby letters of credit outstanding under our senior secured revolving credit facility, which is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. From time to time, we expect to engage in additional capital market, bank credit and other financing activities depending on our needs and financing alternatives available at that time.

Our substantial indebtedness could have important consequences, including the following:

- Our credit agreement and indentures contain, and any future debt obligations may contain, covenants that, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. Our credit agreement also requires us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. The indentures contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions, or consolidate, merge or sell all or substantially all of our or their assets. If we do not comply with these obligations, it may cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

- We may be more vulnerable in the event of a deterioration in our business, in the health care industry or in the economy generally, or if federal or state governments set further limitations on reimbursement under the Medicare or Medicaid programs.

- We are required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which reduces the amount of funds available for our operations, capital expenditures and acquisitions.

- Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our credit agreement and the indentures governing our outstanding senior notes and senior secured notes. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

Table of Contents

We may be unable to successfully integrate Vanguard's business with our business to realize the anticipated benefits of the acquisition or do so within the intended timeframe.

The success of our acquisition of Vanguard will depend, in part, on our ability to integrate Vanguard's business and operations with our business and fully realize the anticipated benefits and synergies from combining our business with Vanguard's business. On October 1, 2013 (the effective date of the acquisition), we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans with approximately 140,000 members. As such, we are devoting significant management attention and resources to integrating the business practices and operations of Vanguard with ours. Potential difficulties we may encounter as part of the integration process include the following:

- The costs of integration and compliance and the possibility that the full benefits anticipated to result from the acquisition will not be realized;
- Delays in the integration of strategies, operations and services;
- Diversion of the attention of our management as a result of the acquisition;
- Differences in business backgrounds, corporate cultures and management philosophies that may delay successful integration;
- Retaining key executives and other employees;
- Challenges associated with creating and enforcing uniform standards, controls, procedures and policies;
- Complexities associated with managing Vanguard as a subsidiary of Tenet, including the challenge of integrating complex systems, technology, networks and other assets of Vanguard into those of Tenet in a manner that minimizes any adverse impact on patients, suppliers, employees and other constituencies;
- Potential unknown liabilities and unforeseen increased expenses or delays associated with the acquisition, including one-time cash costs to integrate Vanguard beyond current estimates; and
- The disruption of, or the loss of momentum in, our ongoing businesses.

If we are unable to successfully overcome the potential difficulties associated with the integration process and achieve our objectives following the acquisition, the anticipated benefits and synergies of the acquisition may not be realized fully, or at all, or may take longer to realize than expected. Any failure to timely realize these anticipated benefits could have a material adverse effect on our business, financial condition, results of operations or cash flows.

The utilization of our tax losses could be substantially limited if we experience an ownership change as defined in the Internal Revenue Code.

At December 31, 2013, we had federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax available to offset future taxable income. These NOL carryforwards will expire in the years 2024 to 2033. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount of taxable income we generate in future periods. There is no assurance that we will be able to fully utilize the NOL carryforwards. Furthermore, we could be required to record a valuation allowance related to the amount of the NOL carryforwards that may not be realized, which could impact our results of operations.

Table of Contents

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The disclosure required under this Item is included in Item 1, Business, of this report.

ITEM 3. LEGAL PROCEEDINGS

For information regarding material pending legal proceedings in which we are involved, see Note 15 to our Consolidated Financial Statements, which is incorporated by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

Table of Contents

PART II.

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." On October 11, 2012, our common stock began trading on the NYSE on a split-adjusted basis following a one-for-four reverse stock split we announced on October 1, 2012. Every four shares of our issued and outstanding common stock were exchanged for one issued and outstanding share of common stock, without any change in the par value per share, and our authorized shares of common stock were proportionately decreased from 1,050,000,000 shares to 262,500,000 shares. No fractional shares were issued in connection with the stock split. The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock on the NYSE, as adjusted to reflect the reverse stock split:

	High	Low
Year Ended December 31, 2013		
First Quarter	$ 48.25	$ 33.00
Second Quarter	49.47	38.17
Third Quarter	47.08	36.87
Fourth Quarter	48.48	38.71
Year Ended December 31, 2012		
First Quarter	$ 24.20	$ 18.36
Second Quarter	22.56	17.32
Third Quarter	25.76	17.24
Fourth Quarter	33.86	22.86

On February 14, 2014, the last reported sales price of our common stock on the NYSE composite tape was $46.56 per share. As of that date, there were 4,356 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

Cash Dividends on Common Stock. We have not paid cash dividends on our common stock since the first quarter of fiscal 1994. We currently intend to retain future earnings, if any, for the operation and development of our business and, accordingly, do not currently intend to pay any cash dividends on our common stock. Our board of directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to pay any cash dividends in the future. Our senior secured revolving credit agreement contains provisions that limit the payment of cash dividends on our common stock if we do not meet certain financial ratios.

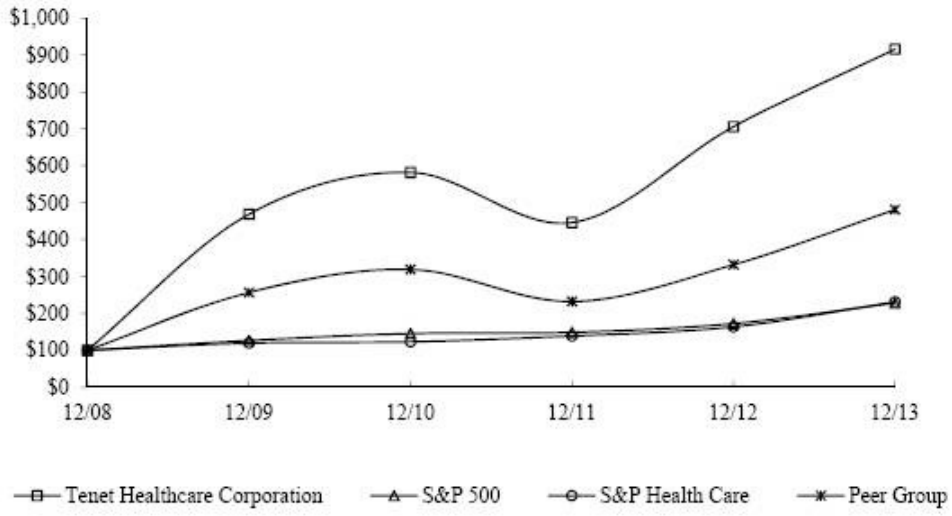
Equity Compensation. Refer to Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of Part III of this report for information regarding securities authorized for issuance under our equity compensation plans.

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to three indices, each of which includes us. The Standard & Poor's 500 Stock Index includes 500 companies representing all major industries. The Standard & Poor's Health Care Composite Index is a group of 55 companies involved in a variety of healthcare-related businesses. Because the Standard & Poor's Health Care Composite Index is heavily weighted by pharmaceutical and medical device companies, we believe that at times it may be less useful than the Hospital Management Peer Group Index included below. We compiled this Peer Group Index by selecting publicly traded companies that have as their primary business the management of acute care hospitals and that have been in business for all five of the years shown. These companies are: Community Health Systems, Inc. (CYH), Health Management Associates, Inc. (HMA), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS).

Table of Contents

Performance data assumes that $100.00 was invested on December 31, 2008 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Stock price performance shown in the graph is not necessarily indicative of future stock price performance.

COMPARISON OF FIVE YEAR CUMULATIVE TOTAL RETURN



	12/08	12/09	12/10	12/11	12/12	12/13
Tenet Healthcare Corporation	$ 100.00	$ 468.70	$ 581.74	$ 446.09	$ 705.87	$ 915.65
S&P 500	$ 100.00	$ 126.46	$ 145.51	$ 148.59	$ 172.37	$ 228.19
S&P Health Care	$ 100.00	$ 119.70	$ 123.17	$ 138.85	$ 163.69	$ 231.55
Peer Group	$ 100.00	$ 256.65	$ 319.12	$ 232.26	$ 332.07	$ 481.22

Repurchase of Common Stock. In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Purchases during the year ended December 31, 2013 are shown in the table in Note 2 to our Consolidated Financial Statements, which table is incorporated by reference.

Table of Contents

ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2009 through 2013. Because we acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013, the 2013 columns in the tables below include results of operations for Vanguard and its consolidated subsidiaries for the three months ended December 31, 2013 only. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2013	2012	2011	2010	2009
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts	$ 12,074	$ 9,904	$ 9,371	$ 8,992	$ 8,785
Less: Provision for doubtful accounts	972	785	717	727	684
Net operating revenues	**11,102**	**9,119**	**8,654**	**8,265**	**8,101**
Operating expenses:					
Salaries, wages and benefits	5,371	4,257	4,015	3,830	3,781
Supplies	1,784	1,552	1,548	1,542	1,534
Other operating expenses, net	2,701	2,147	2,020	1,857	1,831
Electronic health record incentives	(96)	(40)	(55)	—	—
Depreciation and amortization	545	430	398	380	373
Impairment and restructuring charges, and acquisition-related costs	103	19	20	10	27
Litigation and investigation costs, net of insurance recoveries	31	5	55	12	31
Operating income	**663**	**749**	**653**	**634**	**524**
Interest expense	(474)	(412)	(375)	(424)	(445)
Gain (loss) from early extinguishment of debt	(348)	(4)	(117)	(57)	97
Investment earnings	1	1	3	5	—
Net gain on sales of investments	—	—	—	—	15
Income (loss) from continuing operations, before income taxes	**(158)**	**334**	**164**	**158**	**191**
Income tax benefit (expense)	65	(125)	(61)	977	23
Income (loss) from continuing operations, before discontinued operations and cumulative effect of change in accounting principle	**$ (93)**	**$ 209**	**$ 103**	**$ 1,135**	**$ 214**
Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	**$ (1.21)**	**$ 1.77**	**$ 0.58**	**$ 9.09**	**$ 1.67**
Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	**$ (1.21)**	**$ 1.70**	**$ 0.56**	**$ 8.03**	**$ 1.63**

The operating results data presented above is not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services ("CMS") of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; acquisition-related costs; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation

Table of Contents

allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related health care facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local health care competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us that impacts our relationships with physicians and patients; changes in health care regulations and the participation of individual states in federal programs; and the timing of elective procedures.

BALANCE SHEET DATA

	December 31,				
	2013	2012	2011	2010	2009
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 782	$ 918	$ 542	$ 586	$ 689
Total assets	16,130	9,044	8,462	8,500	7,953
Long-term debt, net of current portion	10,690	5,158	4,294	3,997	4,272
Total equity	878	1,218	1,492	1,819	697

CASH FLOW DATA

	Years Ended December 31,				
	2013	2012	2011	2010	2009
	(In Millions)				
Net cash provided by operating activities	$ 589	$ 593	$ 497	$ 472	$ 425
Net cash used in investing activities	(2,164)	(662)	(503)	(420)	(125)
Net cash provided by (used in) financing activities	1,324	320	(286)	(337)	(117)

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is Hospital Operations and other, which is focused on owning and operating acute care hospitals and outpatient facilities. We also operate revenue cycle management, patient communications and engagement services, and management services businesses under our Conifer Health Solutions, LLC ("Conifer") subsidiary, which is a separate reportable business segment. MD&A, which should be read in conjunction with the accompanying Consolidated Financial Statements, includes the following sections:

- Management Overview
- Sources of Revenue
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Recently Issued Accounting Standards
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day and per visit amounts). Continuing operations information includes the results of (i) our same-hospital operations, as described below, and (ii) Vanguard and its consolidated subsidiaries, which we acquired effective October 1, 2013, but only for the period from the date of acquisition through December 31, 2013. Continuing operations

information excludes the results of our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. Same-hospital information includes the results of our operations for all periods presented, including the same 49 hospitals operated during the years ended December 31, 2013, 2012 and 2011 (and any interim periods in those years), but excludes the results of legacy Vanguard operations, as well as our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented. All amounts related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for the reverse stock split described in Item 5, Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities, of this report. Furthermore, certain prior-year amounts have been reclassified to conform to the current-year presentation.

MANAGEMENT OVERVIEW

STRATEGIES AND TRENDS

We are committed to providing the communities our hospitals, outpatient centers and other health care facilities serve with high quality, cost-effective health care while growing our business, increasing our profitability and creating long-term value for our shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed below.

Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to health care providers through Conifer. With respect to our hospitals and outpatient business, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology to remain competitive, to recruit and retain physicians, to increase the number of outpatient centers we own, and to negotiate favorable contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, our management services offerings have expanded to support value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We have made significant investments in the last decade in equipment, technology, education and operational strategies designed to improve clinical quality at our hospitals and outpatient centers. As a result of our efforts, our CMS Hospital Compare Core Measures scores have consistently exceeded the national average since the end of 2005, and major national private payers have also recognized our achievements relative to quality. These designations are expected to become increasingly important as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others. Through our *Commitment to Quality* and *Performance Excellence Program* initiatives, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effect of reducing costs, increasing payments from Medicare and certain managed care payers for our services, and increasing physician and patient satisfaction, which may improve our volumes.

Development Strategies—We remain focused on opportunities to increase our hospital and outpatient revenues through organic growth and acquisitions, and to expand our Conifer business.

From time to time, we build new facilities, make strategic acquisitions of health care assets and companies, and enter into joint venture arrangements or affiliations with health care businesses — in each case in markets where we believe our operating strategies can improve performance and create shareholder value. On October 1, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard. During 2013, we also purchased: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. In addition, we entered into a partnership with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other health care services in the San Francisco Bay area, through which we will jointly develop and expand outpatient services and physician

relationships to improve the efficiency and coordination of care in the Tri-Valley area and nearby communities in Northern California. Furthermore, we have signed a definitive agreement to acquire Emmanuel Medical Center, a 209-bed hospital located in Turlock, California.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the year ended December 31, 2013, we derived approximately 36% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. We believe that growth by strategic acquisitions, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. We continually evaluate collaboration opportunities with outpatient facilities, health care providers, physician groups and others in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality service across the care continuum.

We intend to continue expanding Conifer's revenue cycle management, patient communications and engagement services, and management services businesses by marketing these services to non-Tenet hospitals and other healthcare-related entities. Conifer provides services to more than 700 Tenet and non-Tenet hospital and other clients nationwide. We believe this business has the potential over time to generate high margins and improve our results of operations. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the health care industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals, clients for these services include health plans, self-insured employees and other entities.

Realizing HIT Incentive Payments and Other Benefits—Beginning in the year ended December 31, 2011, we achieved compliance with certain of the health information technology ("HIT") requirements under the American Recovery and Reinvestment Act of 2009 ("ARRA"). In 2013, we recognized approximately $96 million of Medicare electronic health record ("EHR") and Medicaid ARRA HIT incentives in our Consolidated Statement of Operations. These incentives partially offset the operating expenses we have incurred and continue to incur to invest in HIT systems. We expect to recognize additional incentives in the future. Furthermore, we believe that the operational benefits of HIT, including improved clinical outcomes and increased operating efficiencies, will contribute to our long-term ability to grow our business.

General Economic Conditions—We believe that high unemployment rates and other adverse economic conditions are continuing to have a negative impact on our bad debt expense levels, patient volumes and payer mix. However, as the economy recovers, we expect to experience improvements in these metrics relative to current levels.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. Increases in patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher patient co-pays and deductibles, and demographic trends. We continue to pursue integrated contracting models that maximize our system-wide skills and capabilities in conjunction with our strong market positions to accommodate new payment models. In several markets, we have formed clinical integration organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Most recently, in February 2014, we announced that our Abrazo Health network of hospitals in the Phoenix, Arizona area had signed an agreement enabling investment in the funding and expansion of Arizona Care Network. Under the terms of the agreement, Abrazo Health will have a 50% ownership interest in the Arizona Care Network, a clinically integrated network and ACO. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of Affordable Care Act—We anticipate that we will benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") that will extend insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by government payers, we anticipate that we will begin to receive reimbursement for caring for previously uninsured and underinsured patients as early as this year. Through collaborative efforts with local community organizations, we have launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans.

Table of Contents

Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is critical that we continue to make steady and measurable progress in 2014 in successfully integrating Vanguard's business and operations into our business processes. The benefits that come from our larger scale and combined expertise will be fully realized only when we are operating as one efficient and cohesive organization. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

RESULTS OF OPERATIONS—OVERVIEW

Selected Operating Statistics for All Continuing Operations Hospitals —The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the statistics from the hospitals included in the Vanguard acquisition only for the three months ended December 31, 2013. We believe this information is useful to investors because it reflects the significant increase to the scale of our operations as a result of our acquisition of Vanguard.

	Total Hospital Continuing Operations Three Months Ended December 31,		
	2013	2012	Increase (Decrease)
Total admissions	190,506	125,290	52.1%
Adjusted patient admissions(1)	325,410	199,191	63.4%
Surgeries – inpatient	53,119	34,511	53.9%
Surgeries – outpatient	115,611	63,534	82.0%
Total surgeries	168,730	98,045	72.1%
Patient days – total	880,737	580,426	51.7%
Adjusted patient days(1)	1,481,291	915,231	61.8%
Average length of stay (days)	4.62	4.63	(0.2)%
Average licensed beds	20,294	13,216	53.6%
Utilization of licensed beds(2)	47.2%	47.7%	(0.5)%(3)
Total outpatient visits	1,875,684	1,053,499	78.0%
Net inpatient revenues	$ 2,372	$ 1,544	53.6%
Net outpatient revenues	$ 1,357	$ 821	65.3%
Net inpatient revenue per admission	$ 12,451	$ 12,323	1.0%
Net inpatient revenue per patient day	$ 2,693	$ 2,660	1.2%
Net outpatient revenue per visit	$ 723	$ 779	(7.2)%
Net patient revenue per adjusted admission	$ 11,459	$ 11,873	(3.5)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(2) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

(3) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Operating Statistics on a Same-Hospital Basis— Our results of operations have been and continue to be influenced by industry-wide and company-specific challenges, including constrained volume growth and high levels of bad debt, that have affected our revenue growth and operating expenses. We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2013 and 2012 on a same-hospital basis, where noted, excluding the results of the 28 hospitals we acquired from Vanguard on October 1, 2013.

Table of Contents

Admissions, Patient Days and Surgeries	Same-Hospital Continuing Operations Three Months Ended December 31, 2013	2012	Increase (Decrease)
Total admissions	122,404	125,290	(2.3)%
Adjusted patient admissions(1)	198,129	199,191	(0.5)%
Paying admissions (excludes charity and uninsured)	113,573	116,611	(2.6)%
Charity and uninsured admissions	8,831	8,679	1.8%
Admissions through emergency department	76,872	77,465	(0.8)%
Paying admissions as a percentage of total admissions	92.8%	93.1%	(0.3)%(2)
Charity and uninsured admissions as a percentage of total admissions	7.2%	6.9%	0.3%(2)
Emergency department admissions as a percentage of total admissions	62.8%	61.8%	1.0%(2)
Surgeries – inpatient	34,198	34,511	(0.9)%
Surgeries – outpatient	84,878	63,534	33.6%
Total surgeries	119,076	98,045	21.5%
Patient days – total	574,796	580,426	(1.0)%
Adjusted patient days(1)	920,975	915,231	0.6%
Average length of stay (days)	4.70	4.63	1.5%
Average licensed beds	13,179	13,216	(0.3)%
Utilization of licensed beds(3)	47.4%	47.7%	(0.3)%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Total same-hospital admissions decreased by 2,886, or 2.3%, in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. Total surgeries increased by 21.5% in the three months ended December 31, 2013 compared to the same period in 2012, comprised of a 33.6% increase in outpatient surgeries partially offset by a 0.9% decrease in inpatient surgeries. Our emergency department admissions decreased 0.8% in the three months ended December 31, 2013 compared to the same period in the prior year. We believe the current economic conditions continue to have an adverse impact on the level of elective procedures performed at our hospitals, which contributed to the decrease in our total admissions. Charity and uninsured admissions increased 1.8% in the three months ended December 31, 2013 compared to the three months ended December 31, 2012, while paying admissions decreased 2.6%.

Outpatient Visits	Same-Hospital Continuing Operations Three Months Ended December 31, 2013	2012	Increase (Decrease)
Total visits	1,088,194	1,053,499	3.3%
Paying visits (excludes charity and uninsured)	974,396	941,658	3.5%
Charity and uninsured visits	113,798	111,841	1.7%
Emergency department visits	404,950	399,711	1.3%
Surgery visits	84,878	63,534	33.6%
Paying visits as a percentage of total visits	89.5%	89.4%	0.1%(1)
Charity and uninsured visits as a percentage of total visits	10.5%	10.6%	(0.1)%(1)

(1) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Total same-hospital outpatient visits increased 34,695, or 3.3%, in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. All four of our same-hospital regions and our Philadelphia market reported increased outpatient visits in the three months ended December 31, 2013, with the strongest growth occurring in our California and Florida regions. Approximately 39% of the growth in outpatient visits was organic.

Table of Contents

Outpatient surgery visits increased by 33.6% in the three months ended December 31, 2013 compared to the same period in 2012. Charity and uninsured outpatient visits increased by 1.7% in the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Revenues	**2013**	**2012**	**Increase (Decrease)**
Net operating revenues	$ 2,471	$ 2,331	6.0%
Revenues from the uninsured	$ 169	$ 165	2.4%
Net inpatient revenues(1)	$ 1,521	$ 1,544	(1.5)%
Net outpatient revenues(1)	$ 864	$ 821	5.2%

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $72 million and $71 million for the three months ended December 31, 2013 and 2012, respectively. Net outpatient revenues include self-pay revenues of $97 million and $94 million for the three months ended December 31, 2013 and 2012, respectively.

Net operating revenues increased by $140 million, or 6.0%, on a same-hospital basis in the three months ended December 31, 2013 compared to the same period in 2012, primarily due to an increase in outpatient volumes, improved managed care pricing, and increased revenues from services provided by our Conifer subsidiary to third parties, partially offset by a decrease in inpatient volumes. Net operating revenues in the three months ended December 31, 2013 included $71 million of Medicaid disproportionate share hospital ("DSH") and other state-funded subsidy revenues compared to $72 million in the same period in 2012 on a same-hospital basis, which amounts included net revenues related to the California provider fee program of $19 million and $12 million, respectively. Net patient revenues increased by 0.8% in the three months ended December 31, 2013 compared to the same period in 2012.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	**2013**	**2012**	**Increase (Decrease)**
Net inpatient revenue per admission	$ 12,426	$ 12,323	0.8%
Net inpatient revenue per patient day	$ 2,646	$ 2,660	(0.5)%
Net outpatient revenue per visit	$ 794	$ 779	1.9%
Net patient revenue per adjusted patient admission(1)	$ 12,038	$ 11,873	1.4%
Net patient revenue per adjusted patient day(1)	$ 2,590	$ 2,584	0.2%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Net inpatient revenue per admission increased 0.8% in the three months ended December 31, 2013 compared to the same period in 2012. The increase primarily reflects improved terms in our contracts with commercial managed care payers, partially offset by an adverse shift in payer mix. The 1.9% increase in net outpatient revenue per visit was primarily due to the improved terms of our managed care contracts.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Provision for Doubtful Accounts	**2013**	**2012**	**Increase (Decrease)**
Provision for doubtful accounts	$ 205	$ 200	2.5%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.7%	7.9%	(0.2)%(1)
Collection rate on self-pay accounts(2)	28.7%	28.9%	(0.2)%(1)
Collection rate on commercial managed care accounts	98.3%	98.0%	0.3%(1)

(1) The change is the difference between the amounts shown for the three months ended December 31, 2013 compared to the three months ended December 31, 2012.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

Table of Contents

Provision for doubtful accounts increased by $5 million, or 2.5%, in the three months ended December 31, 2013 compared to the same period in 2012. The increase in the absolute amount of provision for doubtful accounts primarily related to an increase in uninsured patient revenues and higher patient co-pays and deductibles in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. Our self-pay collection rate, which is the blended collection rate for uninsured and balance after insurance accounts receivable, was approximately 28.7% at December 31, 2013 and 28.9% at December 31, 2012.

	Same-Hospital Continuing Operations		
	Three Months Ended December 31,		
Selected Operating Expenses	2013	2012	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,050	$ 1,010	4.0%
Supplies	397	388	2.3%
Other operating expenses	535	506	5.7%
Total	$ 1,982	$ 1,904	4.1%
Conifer			
Salaries, wages and benefits	$ 169	$ 81	108.6%
Other operating expenses	59	37	59.5%
Total	$ 228	$ 118	93.2%
Total			
Salaries, wages and benefits	$ 1,219	$ 1,091	11.7%
Supplies	397	388	2.3%
Other operating expenses	594	543	9.4%
Total	$ 2,210	$ 2,022	9.3%
Rent/lease expense(1)			
Hospital Operations and other	$ 35	$ 39	(10.3)%
Conifer	4	3	33.3%
Total	$ 39	$ 42	(7.1)%
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,138	$ 1,103	3.2%
Supplies per adjusted patient day	431	424	1.7%
Other operating expenses per adjusted patient day	562	553	1.6%
Total per adjusted patient day	$ 2,131	$ 2,080	2.5%
Salaries, wages and benefits per adjusted patient admission	$ 5,289	$ 5,071	4.3%
Supplies per adjusted patient admission	2,004	1,948	2.9%
Other operating expenses per adjusted patient admission	2,615	2,540	3.0%
Total per adjusted patient admission	$ 9,908	$ 9,559	3.7%

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

Total selected operating expenses, which is defined as salaries, wages and benefits, supplies and other operating expenses, increased by 2.5% and 3.7% on a per adjusted patient day and per adjusted patient admission basis, respectively, in the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Salaries, wages and benefits per adjusted patient admission increased by approximately 4.3% in the three months ended December 31, 2013 compared to the same period in 2012. This increase is primarily due to an increase in the number of physicians we employ, annual merit increases for certain of our employees and increased contract labor expense in the three months ended December 31, 2013 compared to the three months ended December 31, 2012.

Supplies expense per adjusted patient admission increased by 2.9% in the three months ended December 31, 2013 compared to the three months ended December 31, 2012. The increase in supplies expense was primarily attributable to increased costs of pharmaceuticals and volume growth in our supply-intensive surgical services.

Table of Contents

Other operating expenses per adjusted patient admission increased by 3.0% in the three months ended December 31, 2013 compared to the same period in 2012. This change is primarily due to increased medical fees related to employed physicians and increased malpractice expense, partially offset by decreases in legal and consulting costs. Malpractice expense in the 2013 period included a favorable adjustment of approximately $3 million due to a 43 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an favorable adjustment of $1 million as a result of a 14 basis point increase in the interest rate in the 2012 period.

Salaries, wages and benefits expense for Conifer increased by $88 million in the three months ended December 31, 2013 compared to the three months ended December 31, 2012 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the new CHI partnership, the Vanguard acquisition and Conifer's two acquisitions in the three months ended December 31, 2012.

Other operating expenses for Conifer increased by $22 million in the three months ended December 31, 2013 compared to the three months ended December 30, 2012 primarily due to additional operating expenses related to the new CHI partnership, the Vanguard acquisition and Conifer's two acquisitions in the three months ended December 31, 2012.

The table below shows the pre-tax and after-tax impact on continuing operations for the three months and years ended December 31, 2013 and 2012 of the following items:

	Three Months Ended December 31,		Years Ended December 31,	
	2013	2012	2013	2012
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (58)	$ (7)	$ (103)	$ (19)
Litigation and investigation costs	(28)	(2)	(31)	(5)
Loss from early extinguishment of debt	—	(4)	(348)	(4)
Pre-tax impact	$ (86)	$ (13)	$ (482)	$ (28)
Total after-tax impact	$ (60)	$ (8)	$ (315)	$ (18)
Diluted per-share impact of above items	$ (0.60)	$ (0.08)	$ (3.06)	$ (0.17)
Diluted earnings (loss) per share, including above items	$ (0.17)	$ 0.52	$ (1.21)	$ 1.70

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $113 million at December 31, 2013, an increase of $31 million from $82 million at September 30, 2013.

Significant cash flow items in the three months ended December 31, 2013 included:

- Capital expenditures of $293 million;
- Interest payments of $131 million;
- Payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements of $78 million;
- $195 million of net proceeds from borrowings under our revolving credit facility;
- $1.373 billion of payments to acquire Vanguard and various outpatient, physician practice and other healthcare-related businesses, net of cash acquired;
- $100 million of payments to repurchase common stock;
- $3.125 billion of payments to retire Vanguard long-term debt; and
- $4.600 billion of proceeds from the issuance of our 6% senior secured notes due 2020 ($1.800 billion) and 8 1/8% senior notes due 2020 ($2.800 billion).

Table of Contents

Net cash provided by operating activities was $589 million in the year ended December 31, 2013 compared to $593 million in the year ended December 31, 2012. Key negative and positive factors contributing to the change between the 2013 and 2012 periods include the following:

- Increased income from continuing operations before income taxes of $139 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, litigation and investigation costs, impairment and restructuring charges, acquisition-related costs, and depreciation and amortization in the year ended December 31, 2013 compared to the year ended December 31, 2012;
- The unfavorable impact of increased DSH receivables of $30 million primarily related to the Texas uncompensated care 1115 waiver program;
- $20 million less cash used in operating activities from discontinued operations;
- An increase of $51 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;
- $50 million of additional interest payments primarily due to $37 million of interest payments related to the Vanguard debt refinanced in connection with the acquisition on October 1, 2013; and
- Income tax payments of $6 million in the year ended December 31, 2013 compared to $13 million in the year ended December 31, 2012.

SOURCES OF REVENUE

We receive revenues for patient services from a variety of sources, primarily managed care payers and the federal Medicare program, as well as state Medicaid programs, indemnity-based health insurance companies and self-pay patients (that is, patients who do not have health insurance and are not covered by some other form of third-party arrangement).

The table below shows the sources of net patient revenues before provision for doubtful accounts for our general hospitals, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Years Ended December 31,		
Net Patient Revenues from:	**2013**	**2012**	**2011**
Medicare	21.8%	23.4%	23.1%
Medicaid	9.0%	8.4%	9.0%
Managed care	58.1%	57.4%	57.2%
Indemnity, self-pay and other	11.1%	10.8%	10.7%

Our payer mix on an admissions basis for our general hospitals, expressed as a percentage of total admissions from all sources, is shown below:

	Years Ended December 31,		
Admissions from:	**2013**	**2012**	**2011**
Medicare	28.0%	28.9%	29.6%
Medicaid	11.7%	12.2%	12.8%
Managed care	50.0%	48.8%	47.9%
Indemnity, self-pay and other	10.3%	10.1%	9.7%

Table of Contents

GOVERNMENT PROGRAMS

The Medicare program, the nation's largest health insurance program, is administered by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services ("HHS"). Medicare is a health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources, and is jointly funded by the federal government and state governments. Medicaid is the largest source of funding for medical and health-related services for the nation's poor and most vulnerable individuals.

The Affordable Care Act is changing how health care services in the United States are covered, delivered and reimbursed. One key provision of the Affordable Care Act is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. For individuals who are not exempt from the individual mandate, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Also beginning in 2014, those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty. The "employer mandate" provision of the Affordable Care Act requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. On July 2, 2013, the U.S. Treasury Department announced a one-year delay (to January 1, 2015) in the imposition of penalties and the reporting requirements of the employer mandate. On February 10, 2014, the requirements of the employer mandate were further delayed until January 1, 2016. Based on the Congressional Budget Office's most recent estimates, we do not believe that the delays in the employer mandate will have a discernible effect on insurance coverage. Another key provision of the Affordable Care Act is the expansion of Medicaid coverage. Prior to the passage of the ACA, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The ACA expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. The expansion of the Medicaid program (which will be substantially funded by the federal government) in each state will require state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. As of December 31, 2013, 25 states and the District of Columbia have taken action to expand Medicaid and four others are considering action. We currently operate hospitals in five of the states that are expanding and two of the states that are considering expansion. We cannot provide any assurances as to whether or when the other states in which we operate might choose to expand their Medicaid programs. We anticipate that health care providers will generally benefit over time from insurance coverage provisions of the Affordable Care Act; however, the ACA also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including: (1) negative adjustments to the annual market basket updates for Medicare inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and (2) reductions to Medicare and Medicaid DSH payments beginning, with respect to Medicare payments, in federal fiscal year ("FFY") 2014 and, with respect to Medicaid payments, in FFY 2016, as the number of uninsured individuals declines. We are unable to predict the ultimate net effect of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding the ultimate number of uninsured patients who will obtain insurance coverage, uncertainty regarding future negotiations with payers, uncertainty regarding Medicaid expansion, and gradual and, in some cases, delayed implementation. Furthermore, we are unable to predict what action, if any, Congress might take with respect to the Affordable Care Act or the actions individual states might take with respect to expanding Medicaid coverage.

The Medicare and Medicaid programs are also subject to statutory and regulatory changes, administrative and judicial rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are unable to predict the effect of future government health care funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government health care program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage

Table of Contents

(sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues, including our general hospitals and other operations, for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2013, 2012, and 2011 are set forth in the following table:

	Years Ended December 31,		
Revenue Descriptions	**2013**	**2012**	**2011**
Medicare severity-adjusted diagnosis-related group – operating	$ 1,201	$ 1,109	$ 1,126
Medicare severity-adjusted diagnosis-related group – capital	107	98	100
Outliers	53	51	44
Outpatient	632	522	462
Disproportionate share	250	217	214
Direct Graduate and Indirect Medical Education(1)	138	96	97
Other(2)	42	66	70
Adjustments for prior-year cost reports and related valuation allowances	32	109	—
Total Medicare net patient revenues	**$ 2,455**	**$ 2,268**	**$ 2,113**

(1) Includes Indirect Medical Education revenue earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.
(2) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

A general description of the types of payments we receive for services provided to patients enrolled in the Original Medicare Plan is provided below. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found below under "Regulatory and Legislative Changes."

Acute Care Hospital Inpatient Prospective Payment System

Medicare Severity-Adjusted Diagnosis-Related Group Payments—Sections 1886(d) and 1886(g) of the Social Security Act (the "Act") set forth a system of payments for the operating and capital costs of inpatient acute care hospital admissions based on a prospective payment system ("PPS"). Under the inpatient prospective payment systems ("IPPS"), Medicare payments for hospital inpatient operating services are made at predetermined rates for each hospital discharge. Discharges are classified according to a system of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), which categorize patients with similar clinical characteristics that are expected to require similar amounts of hospital resources. CMS assigns to each MS-DRG a relative weight that represents the average resources required to treat cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. Using diagnosis and procedure information submitted by the hospital, CMS assigns to each discharge an MS-DRG, and the base payments are multiplied by the relative weight of the MS-DRG assigned. The MS-DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not take into consideration an individual hospital's operating and capital costs.

Outlier Payments— Outlier payments are additional payments made to hospitals on individual claims for treating Medicare patients whose medical conditions are costlier to treat than those of the average patient in the same MS-DRG. To qualify for a cost outlier payment, a hospital's billed charges, adjusted to cost, must exceed the payment rate for the MS-DRG by a fixed threshold established annually by CMS. A Medicare administrative contractor ("MAC") calculates the cost of a claim by multiplying the billed charges by a cost-to-charge ratio that is typically based on the hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Act, CMS must project aggregate annual outlier payments to all PPS hospitals to be not less than 5% or more than 6% of total MS-DRG payments ("Outlier Percentage"). The Outlier Percentage is determined by dividing total outlier

payments by the sum of MS-DRG and outlier payments. CMS annually adjusts the fixed threshold to bring projected outlier payments within the mandated limit. A change to the fixed threshold affects total outlier payments by changing: (1) the number of cases that qualify for outlier payments; and (2) the dollar amount hospitals receive for those cases that still qualify for outlier payments.

Disproportionate Share Hospital Payments— In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately high share of low-income patients. Prior to October 1, 2013, DSH payments were determined annually based on certain statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. Section 3133 of the Affordable Care Act revises the Medicare DSH adjustment effective for discharges occurring on or after October 1, 2014. Under the revised methodology, hospitals will receive 25% of the amount they previously would have received under the pre-ACA formula. This amount is referred to as the "Empirically Justified Amount."

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC DSH Amount"). The UC DSH Amount is a hospital's share of a pool of funds that equal 75% of what otherwise would have been paid as Medicare DSH, adjusted for changes in the percentage of individuals that are uninsured. For FFY 2014, each Medicare DSH hospital's share of the UC DSH Amount pool is based on its share of insured low income days reported by all Medicare DSH hospitals.

During 2013, 68 of our hospitals in continuing operations qualified for DSH payments. One of the variables used in the pre-ACA DSH formula is the number Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Medicare Traditional patients, but also Medicare Advantage patients in the SSI ratio. During the three months ended March 31, 2012, CMS released revised SSI ratios for FFYs 2006 and 2007, and SSI ratios for FFYs 2008 and 2009, which, according to CMS, include the Medicare Advantage days; the SSI ratios for subsequent periods also include the Medicare Advantage days. Beginning in 2009, we established reserves for the estimated impact of including the Medicare Advantage days in the SSI ratio, and during 2013, cost report settlements for substantially all of the periods for which we established reserves were settled.

The Medicare DSH statutes and regulations have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in these appeals, including challenges to the inclusion of Medicare Advantage days in the SSI ratios. These types of appeals generally take several years to resolve, particularly for multi-hospital organizations, because of CMS' administrative appeal rules. During the three months ended December 31, 2012, the federal district court in the District of Columbia ruled in *Allina Health Services v. Sebelius ("Allina")* that the Secretary of HHS failed to follow the Administrative Procedures Act when promulgating the regulation requiring the inclusion of the Medicare Advantage days in the SSI ratios. The court remanded the matter to the Secretary and vacated the regulation it found to be improperly promulgated. Subsequently, the Secretary appealed the district court's order. Oral arguments in *Allina* were heard at the U.S. Court of Appeals for the D.C. Circuit Court in February 2014. Our DSH SSI appeals are pending; however, the outcome of the aforementioned case could influence the disposition of our appeals. We cannot predict the timing or outcome of our DSH appeals; however, a favorable outcome of our appeals could have a material impact on our future revenues and cash flows. We are also not able to predict what additional action the Secretary might take with respect to the regulation vacated by the district court.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") payments. During 2013, 29 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments. Medicare rules permit teaching hospitals to enter into Medicare Graduate Medical Education Affiliation Agreements for the purpose of applying the FTE limits on an aggregate basis, and some of our teaching hospitals have entered into such agreements.

Hospital Outpatient Prospective Payment System

Under the outpatient prospective payment system, hospital outpatient services, except for certain services that are reimbursed on a separate fee schedule, are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require, and a payment rate is established for each APC.

Table of Contents

Depending on the services provided, hospitals may be paid for more than one APC for an encounter. CMS periodically updates the APCs and annually adjusts the rates paid for each APC.

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient prospective payment system. The IPF-PPS is based on prospectively determined per-diem rates and includes an outlier policy that authorizes additional payments for extraordinarily costly cases.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system.

To be paid under the IRF-PPS, each hospital or unit must demonstrate on an annual basis that at least 60% of its total population had either a principal or secondary diagnosis that fell within one of 13 diagnosis categories or have qualifying conditions designated in the Medicare regulations governing IRFs. As of December 31, 2013, all of our rehabilitation units were in compliance with the required 60% threshold.

Physician Services Payment System

Medicare pays for physician and other professional services based on a list of services and their payment rates, called the Medicare Physician Fee Schedule ("MPFS"). In determining payment rates for each service on the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations and other factors. The conversion factor updates payments for physician services every year according to a formula called the sustainable growth rate ("SGR") system. This formula is intended to keep spending growth (a function of service volume growth) consistent with growth in the national economy. However, in the last several years, Congress has specified an update outside of the SGR formula. Because of budget neutrality requirements, these payment updates have largely been funded by payment reductions to other providers, including hospitals.

Cost Reports

The final determination of certain Medicare payments to our hospitals, such as DSH, DGME, IME and bad debt expense, are retrospectively determined based on our hospitals' cost reports. The final determination of these payments often takes many years to resolve because of audits by the program representatives, providers' rights of appeal, and the application of numerous technical reimbursement provisions.

For filed cost reports, we adjust the accrual for estimated cost report settlements based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for estimated cost report settlements for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports and a corresponding valuation allowance is recorded as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, excluding state-funded managed care Medicaid programs, constituted approximately 9.0%, 8.4% and 9.0% of net patient revenues before provision for doubtful accounts at our continuing general hospitals for the years ended December 31, 2013, 2012 and 2011, respectively. We also receive DSH payments under various state Medicaid programs. For the years ended December 31, 2013, 2012 and 2011, our revenues attributable to DSH payments and other state-funded subsidy payments were approximately $428 million, $283 million

and $255 million, respectively. The 2013 amount includes three months of revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013.

Several states in which we operate continue to face budgetary challenges due to the economic downturn and other factors that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce their Medicaid expenditures. In addition, some states are implementing delays in issuing Medicaid payments to providers. As an alternative means of funding provider payments, many of the states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

During the year ended December 31, 2013, we recorded net revenues of $115 million related to California Hospital Quality Assurance Fee ("HQAF") program. The Governor of California signed the HQAF renewal bill into law in October 2013, extending California's provider fee program for three years (with a framework to renew the program for at least three additional years beyond 2016) and reversing Medi-Cal cuts for some hospital skilled-nursing facilities, among other things. Based on the most recent estimates from the California Hospital Association, the extension of the HQAF program authorized by the legislation will result in additional revenues for our hospitals, net of provider fees and other expenses, of approximately $475 million over the three-year period ending December 31, 2016.

During the three months ended December 31, 2012, certain of our Texas hospitals began to participate in the Texas 1115 demonstration waiver approved by CMS in December 2011 to replace the state's Upper Payment Limit program. The waiver term covers state fiscal years September 1, 2012 through August 31, 2016, is funded by intergovernmental transfer payments from local government entities, and includes two funding pools — Uncompensated Care and Delivery System Reform Payment. We recognized $15 million of revenues associated with this 1115 waiver program during the three months ended December 31, 2012. Separately, during the same period we incurred $13 million of expenses related to funding indigent care services by certain of our Texas hospitals. In 2013, we recognized $94 million of revenues from the Texas 1115 waiver programs, and we incurred $55 million of expense related to funding indigent care services by certain of our Texas hospitals. We cannot provide any assurances as to the ultimate amount of revenues that our hospitals may receive from this program in 2014.

Because we cannot predict what actions the federal government or the states may take under existing legislation and future legislation to address budget gaps or deficits, we are unable to assess the effect that any such legislation might have on our business, but the impact on our future financial position, results of operations or cash flows could be material.

Medicaid-related patient revenues recognized by our continuing general hospitals from Medicaid-related programs in the states in which they are located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2013, 2012 and 2011 are set forth in the table below:

	Years Ended December 31,					
	2013		2012		2011	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
California	$ 242	$ 164	$ 198	$ 148	$ 221	$ 127
Florida	178	65	178	61	184	60
Texas	151	151	67	123	64	114
Georgia	77	35	85	38	88	40
Pennsylvania	74	200	72	209	91	195
Michigan	64	96	—	—	—	—
Missouri	64	6	70	5	52	5
North Carolina	34	5	40	—	23	—
Illinois	33	6	—	—	—	—
South Carolina	22	25	34	25	40	22
Alabama	13	—	31	—	29	—
Arizona	9	21	—	—	—	—
Massachusetts	9	8	—	—	—	—
Tennessee	6	27	8	29	10	30
	$ 976	**$ 809**	**$ 783**	**$ 638**	**$ 802**	**$ 593**

Table of Contents

Regulatory and Legislative Changes

Recent regulatory and legislative updates to the Medicare and Medicaid payment systems are provided below.

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the IPPS. The updates generally become effective October 1, the beginning of the federal fiscal year. On August 2, 2013, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2014 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.5% for MS-DRG operating payments for hospitals reporting specified quality measure data (hospitals that do not report specified quality measure data would receive an increase of 0.5%); CMS is also making certain adjustments to the 2.5% market basket increase that result in a net market basket update of 0.7%, including:
  - Market basket index and multifactor productivity reductions required by the Affordable Care Act of 0.3% and 0.5%, respectively;
  - A documentation and coding recoupment reduction of 0.8% as part of the recoupment required by the American Taxpayer Relief Act of 2012; and
  - A 0.2% reduction to offset the cost of a policy on admission and medical review criteria;
- A methodology to implement Medicare DSH reductions required by the Affordable Care Act;
- A 0.9% net increase in the capital federal MS-DRG rate; and
- A decrease in the cost outlier threshold from $21,821 to $21,748.

The aforementioned admission and medical review criteria for which CMS imposed a 0.2% reduction to the market basket establishes a new policy (referred to as "the two-midnight rule") with respect to how short hospital stays will be paid. Generally, under the two-midnight rule, claims for inpatient admissions spanning two or more midnights may continue to be billed as inpatient care under the IPPS. The new policy requires, with a few limited exceptions, hospital stays that are shorter than "two midnights" to be categorized as outpatient care and billed under the OPPS. In September 2013, CMS instructed its contractors to delay enforcement of the two-midnight rule for 90 days; CMS subsequently extended the enforcement delay through September 30, 2014. Our hospitals, along with many other hospitals nationally, are participating in a challenge to CMS's calculation of the 0.2% reduction to the IPPS market basket associated with the two-midnight rule.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 1.0% increase in payments for hospitals in large urban areas (populations over one million). Using the impact percentages in the Final IPPS Rule as applied to our IPPS payments for the 12 months ended September 30, 2013, the estimated annual impact for all changes in the Final IPPS Rule on our hospitals is an increase in our Medicare inpatient revenues of approximately $23 million. Because of the uncertainty associated with the other factors that may influence our future IPPS payments by individual hospital, including legislative action, regulatory and policy changes, admission volumes, length of stay, case mix, the redistributive effects of the Medicare DSH reductions and the two-midnight rule, we cannot provide any assurances regarding our estimate.

Payment Changes to the Medicare Inpatient Psychiatric Facility Prospective Payment System

On July 29, 2013, CMS issued a notice updating the prospective payment rates for the Medicare inpatient psychiatric facility ("IPF") prospective payment system ("IPF-PPS") for FFY 2014 ("IPF-PPS Notice"). The IPF-PPS Notice includes the following payment and policy changes:

- A net payment increase for IPFs of 2.0%, which reflects a market basket index increase of 2.6%, reduced by a productivity adjustment of 0.5% and an additional 0.1%, both as required by the Affordable Care Act, as well as other adjustments, including a budget neutrality reduction; and

- A decrease in the outlier threshold from $11,600 to $10,245, which CMS estimates will yield an additional 0.3% increase total IPF-PPS payments.

At December 31, 2013, 18 of our general hospitals operated inpatient psychiatric units reimbursed under the IPF-PPS. CMS projects that the combined impact of the payment and policy changes included in the IPF-PPS Notice will yield an average 2.3% increase in payments for all IPFs (including psychiatric units in acute care hospitals) and an average 2.5% increase in payments for psychiatric units of acute care hospitals located in urban areas for FFY 2014. Using the urban psychiatric unit impact percentage as applied to our IPF-PPS payments for the 12 months ended September 30, 2013, the annual impact of all payment and policy changes in the IPF-PPS Notice on our IPF-PPS psychiatric units may result in an estimated increase in our Medicare revenues of approximately $1 million. Because of the uncertainty associated with various factors that may influence our future IPF-PPS payments, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the aforementioned changes.

Payment and Policy Changes to the Medicare Inpatient Rehabilitation Facility Prospective Payment System

On July 31, 2013, CMS issued final changes to the Medicare inpatient rehabilitation facility ("IRF") prospective payment system ("IRF-PPS") for FFY 2014 ("IRF-PPS Final Rule"). The IRF-PPS Final Rule includes the following payment and policy changes:

- A net update to IRF-PPS payments equal to 1.8% resulting from the estimated market basket of 2.6%, minus an estimated productivity adjustment of 0.5% and a market basket reduction of 0.3%, both of which are required under certain provisions of the Affordable Care Act; and

- A reduction in the number of diagnosis codes from the list used to determine an IRF's presumptive compliance with the "60 percent rule."

At December 31, 2013, 16 of our general hospitals operated inpatient rehabilitation units. CMS projects that the payment changes in the IRF-PPS Final Rule will result in an estimated total increase in aggregate IRF payments of 2.3%. This estimated increase includes an average 2.8% increase for rehabilitation units in hospitals located in urban areas for FFY 2014. Using the urban rehabilitation unit impact percentage as applied to our Medicare IRF payments for the 12 months ended September 30, 2013, the annual impact of the payment and policy changes in the IRF-PPS Final Rule on the inpatient rehabilitation units we operated on that date may result in an estimated increase in our Medicare revenues of less than $1 million. Because of the uncertainty associated with various factors that may influence our future IRF payments, including legislative action, admission volumes, length of stay and case mix, and the impact of compliance with admission criteria, we cannot provide any assurances regarding our estimate of the impact of these changes.

Payment and Policy Changes to the Medicare Outpatient Prospective Payment System

On November 27, 2013, CMS released the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rules for the calendar year 2014 ("Final OPPS Rule"). The Final OPPS Rule includes the following payment and policy changes:

- A net update to OPPS payments equal to 1.7% resulting from the estimated market basket of 2.5%, minus an estimated productivity adjustment of 0.5% and a market basket reduction of 0.3%, both of which are required under certain provisions of the Affordable Care Act;

- The discontinuation of multiple codes for hospital clinic departments and conversion to single codes for those services; and

- An increase in the number of items and services that are packaged into the OPPS Ambulatory Payment Classification payments.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS Rule will yield an average 1.9% increase in payments for all hospitals and an average 2.0% increase in payments for hospitals in large urban areas (populations over one million). According to CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS Rule on the hospitals we owned on December 31, 2013 is an $27 million increase in Medicare outpatient revenues. Because of the uncertainty associated with the proposals, and other factors that may influence our future

Table of Contents

OPPS payments by individual hospital, including legislative action, patient volumes and case mix, we cannot provide any assurances regarding this estimate.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On November 27, 2013, CMS released the final update to the Medicare Physician Fee Schedule ("MPFS") for calendar year 2014. The MPFS is the schedule of rates Medicare pays for physician and other professional services and is updated annually. The MPFS update is determined by the "sustainable growth rate" ("SGR") formula in accordance with the Balanced Budget Act of 1997. CMS estimates that the calendar year 2014 update to the MPFS would result in a reduction to payments of approximately 20.1%. For the past 10 years, negative adjustments to the MPFS resulting from the SGR formula have been overridden by Congress. Because of budget neutrality requirements, these overrides have been funded in part with reductions to hospital and other provider payments. On December 26, 2013, the President signed into law House Joint Resolution 59, also known as the Bipartisan Budget Act of 2013 and the Pathway for SGR Reform Act of 2013. The resolution averts the 20.1% reduction and replaces it with a 0.5% increase to the conversion factor for the MPFS through March 31, 2014.

Although the historical pattern suggests that Congress will override the SGR formula reduction for the remainder of 2014, we cannot provide any assurances in that regard. Because a temporary or permanent change to the SGR formula would likely involve payment reductions to other providers (including hospitals), we cannot predict what impact such changes would have on our future net revenues or cash flows.

Medicare Claims Reviews

HHS estimates that approximately 10.1% of all Medicare Fee-For-Service ("FFS") claim payments in FFY 2013 were improper. The Improper Payments Information Act of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010, requires the heads of federal agencies, including HHS, to annually review programs it administers to:

- Identify programs that may be susceptible to significant improper payments;
- Estimate the amount of improper payments in those programs;
- Submit those estimates to Congress; and
- Describe the actions the agency is taking to reduce improper payments in those programs.

CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. As a result, in addition to the Recovery Audit Contractor ("RAC") program, which currently performs post-payment claims reviews, CMS has recently established initiatives to prevent improper payments before a claim is processed. These initiatives include a significant increase in the number of prepayment claims reviews performed by MACs.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment claims denials are subject to administrative and judicial review. We have established robust protocols to respond to claims reviews and payment denials. Payment recoveries resulting from MAC reviews can be appealed through administrative and judicial processes, and we intend to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

Affordable Care Act

The ACA is changing how health care services in the United States are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced growth and other reductions in Medicare program spending, and the establishment of programs where reimbursement is tied to quality and integration. In addition, the law reforms certain aspects of

health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality, and contains provisions intended to strengthen fraud and abuse enforcement. The expansion of health insurance coverage under the ACA may result in a material increase in the number of patients using our facilities who have either private or public program coverage. On the other hand, the ACA provides for significant reductions in Medicare market basket updates and decreases in Medicare and Medicaid DSH payments. Given that approximately 31% of our net patient revenues before provision for doubtful accounts in 2013 were from Medicare and Medicaid, reductions to these programs may significantly impact us and could offset any positive effects of the ACA.

In addition to increasing funding for the CMS Medicaid Integrity Program, which employs Medicaid Integrity Contractors to audit Medicaid claims, the ACA expanded the RAC program's scope to include Medicare Advantage plans and Medicaid claims beginning in 2012. We cannot predict with certainty the impact of these programs on our future results of operations or cash flows.

As described in greater detail under Item 1, Business — Health Care Regulation and Licensing, of Part I of this report, there is significant uncertainty with respect to the positive and negative effects the ACA may have on reimbursement, utilization and the future design of provider networks and insurance plans (including pricing, provider participation, coverage, co-pays and deductibles), and the multiple models that attempt to predict those effects may differ materially from our expectations. Because of the many variables involved, we are unable to predict the ultimate net effect on our future revenues and operations of the expected decreases in uninsured individuals using our facilities, the reductions in Medicare spending and Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us.

The American Recovery and Reinvestment Act of 2009

The ARRA was enacted to stimulate the U.S. economy. One provision of ARRA provides financial incentives to hospitals and physicians to become "meaningful users" of electronic health records. The Medicare incentive payments to individual hospitals are made over a four-year, front-weighted transition period. The Medicaid incentive payments, which are administered by the states, are subject to more flexible payment and compliance standards than Medicare incentive payments; hospitals that achieve compliance between 2014 and 2015 will receive reduced incentive payments during the transition period.

We anticipate that we will incur selected operating expenses related to our overall HIT program of approximately $145 million in 2014 compared to approximately $105 million of Medicare and Medicaid EHR incentive payments we expect to recognize. In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Hospitals that fail to become meaningful users of EHRs or fail to submit quality data by 2015 will be subject to penalties in the form of a reduction to Medicare payments. This reduction, which will be based on the market basket update, will be phased in over three years and will continue until a hospital achieves compliance. Should all of our hospitals, including those acquired as part of the Vanguard acquisition, fail to become meaningful users of EHRs and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of approximately $15 million, $35 million and $55 million in 2015, 2016, and 2017 and subsequent years, respectively.

During the year ended December 31, 2013, we recognized approximately $96 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of 54 of our hospitals and certain of our employed physicians demonstrating meaningful use of certified EHR technology. These incentives partially offset approximately $117 million of selected operating expenses we incurred in 2013 related to our overall HIT program. The final Medicare EHR incentive payments are determined when the cost report that begins in the federal fiscal year during which the hospital achieved meaningful use is settled. Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

The complexity of the changes required to our hospitals' systems and the time required to complete the changes will likely result in some or all of our hospitals not being fully compliant in time to be eligible for the maximum HIT funding permitted under ARRA. Because of the uncertainties regarding the implementation of HIT, including CMS' future EHR implementation regulations, the ability of our hospitals to achieve compliance and the associated costs, we cannot provide any assurances regarding the aforementioned estimates.

Table of Contents

The American Taxpayer Relief Act of 2012

The American Taxpayer Relief Act of 2012 delayed by two months the effective date of the automatic reductions (referred to as "sequestration") in federal spending, including a 2% reduction in Medicare payments, mandated by the Budget Control Act of 2011 that was originally scheduled to take effect on February 1, 2013. On March 1, 2013, the President signed an order to begin the sequestration. Effective April 1, 2013, all Medicare payments to providers began to be reduced by 2% and will continue to be paid at the reduced rate as long as the sequestration is in effect. As of December 31, 2013, Congress had not taken any action to reduce or eliminate the sequestration adjustment. Any such action would likely require other payments reductions in order to maintain budget neutrality. We cannot predict how long the sequestration will be in effect, nor can we predict what Medicare payment, eligibility and coverage changes, if any, will be enacted in lieu of the sequestration.

The Continuing Appropriations and Consolidated Appropriations Acts of 2014

On October 17, 2013, the President signed the Continuing Appropriations Act, 2014 into law, which provided FFY 2014 appropriations for projects and activities of the federal government at sequestration levels through January 15, 2014 and extended the U.S. debt limit through February 7, 2014. The law also included provisions intended to strengthen eligibility verification of those who apply for insurance subsidies under the Affordable Care Act. On January 17, 2014, the President signed the Consolidated Appropriations Act of 2014 into law, which continues appropriations for FFY 2014, but does not provide any new funding for the ACA. We cannot predict what further actions Congress or the President may take with respect to appropriations or the debt limit or the effect, if any, of such actions on our net revenues or cash flows.

The Bipartisan Budget Act of 2013

As described above, the Bipartisan Budget Act of 2013 averted a 20.1% reduction to payments under the MPFS and replaced it with a 0.5% increase for the period January 1, 2014 through March 31, 2014. Other significant Medicare and Medicaid provisions of the Bipartisan Budget Act included:

- A delay in the reductions to Medicaid DSH allotments to states required under the ACA until FFY 2016 (the reductions were originally scheduled to begin in FFY 2014);
- A continuation of the Medicare sequestration reductions through the remainder of FFY 2014; and
- An extension of the sequestration for mandatory programs, including Medicare, for another two years through 2023.

MedPAC FFY 2014 Recommendations

Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems. Generally, the MedPAC opposes sequestration as a way to reduce payments, particularly below the base rate, because the MedPAC favors a more targeted approach to achieve savings. In January 2014, the MedPAC voted in favor of three recommendations for hospital inpatient and outpatient services, two of which affect acute care hospitals. Specifically, the MedPAC voted that Congress should direct HHS to:

- Reduce or eliminate the differences in payment rates between outpatient departments and physicians' offices for selected APCs; and
- Increase payment rates for the IPPS and OPPS in FFY 2015 by 3.25%.

We expect these recommendations to be included in the forthcoming MedPAC Annual Report to Congress. Congress is not obligated to adopt the MedPAC recommendations and, based on outcomes in previous years, there can be no assurance Congress will adopt such recommendations in a given year. We cannot predict what actions, if any, Congress, HHS or CMS will take with respect to the MedPAC recommendations or the effect, if any, of such actions on our net revenues or cash flows.

Extension of Medicare Sequestration

In February 2014, the President signed into law legislation that includes the restoration of certain military pension benefits and extension of the Medicare sequestration payment reductions for an additional year through FFY 2014.

PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service health care delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate health care can be efficiently delivered in the most cost-effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted health care providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted health care providers. PPO members who use contracted health care providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible health care plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient revenues during the years ended December 31, 2013, 2012 and 2011 was $6.3 billion, $5.4 billion and $5.1 billion, respectively. Approximately 59% of our managed care net patient revenues for the year ended December 31, 2013 was derived from our top ten managed care payers. Approximately 44% of the total net managed care revenues of our same-hospitals owned for at least one year was generated from national payers. The remainder comes from regional or local payers. At December 31, 2013 and 2012 approximately 58% and 52%, respectively, of our net accounts receivable related to continuing operations were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of December 31, 2013, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $13 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have had improved year-over-year managed care pricing, we expect some moderation in the pricing percentage increases in future years. It is not clear what impact, if any, the increased obligations on managed care and other payers imposed by the Affordable Care

Act will have on our commercial managed care volumes and payment rates. In the year ended December 31, 2013, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

An indemnity-based agreement generally requires the insurer to reimburse an insured patient for health care expenses after those expenses have been incurred by the patient, subject to policy conditions and exclusions. Unlike an HMO member, a patient with indemnity insurance is free to control his or her utilization of health care and selection of health care providers.

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant portion of our self-pay patients is admitted through our hospitals' emergency departments and often requires high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe that our level of self-pay patients has been higher in the last several years than previous periods due to a combination of broad economic factors, including increased unemployment rates, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-pays and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectability problems. At both December 31, 2013 and 2012, approximately 7% of our net accounts receivable related to continuing operations were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have been increasing our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

Over the longer term, several other initiatives we have previously announced should also help address this challenge. For example, our *Compact with Uninsured Patients* ("Compact") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically have been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

Under the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), a new Consumer Financial Protection Bureau ("CFPB") was formed within the U.S. Federal Reserve to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. We believe that the CFPB regulatory and enforcement processes will have a significant impact on Conifer's operations. For additional information, see Item 1, Business — Regulations Affecting Conifer, of Part I of this report.

Our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the years ended December 31, 2013, 2012 and 2011 were approximately $545 million, $430 million and $379 million, respectively. We also provide charity care to patients who are financially unable to pay for the health care services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the years ended December 31, 2013, 2012

Table of Contents

and 2011 were approximately $428 million, $283 million and $255 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the years ended December 31, 2013, 2012 and 2011 were $158 million, $136 million and $113 million, respectively. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues.

The expansion of health insurance coverage under the Affordable Care Act may result in a material increase in the number of patients using our facilities who have either health insurance exchange or government health care insurance program coverage. However, because of the many variables involved, we are unable to predict with certainty the net impact on us of the expected increase in revenues and expected decrease in bad debt expense from providing care to previously uninsured and underinsured individuals, and numerous other provisions in the law that may affect us. In addition, even after implementation of the Affordable Care Act, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage under the Affordable Care Act and for undocumented aliens who will not be permitted to enroll in a health insurance exchange or government health care insurance program.

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2013 COMPARED TO THE YEAR ENDED DECEMBER 31, 2012

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2013 and 2012:

	Years Ended December 31,		
	2013	2012	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 10,888	$ 9,436	$ 1,452
Other operations	1,186	468	718
Net operating revenues before provision for doubtful accounts	12,074	9,904	2,170
Less provision for doubtful accounts	972	785	187
Net operating revenues	**11,102**	**9,119**	**1,983**
Operating expenses:			
Salaries, wages and benefits	5,371	4,257	1,114
Supplies	1,784	1,552	232
Other operating expenses, net	2,701	2,147	554
Electronic health record incentives	(96)	(40)	(56)
Depreciation and amortization	545	430	115
Impairment of long-lived assets and goodwill, and restructuring charges	103	19	84
Litigation and investigation costs	31	5	26
Operating income	**$ 663**	**$ 749**	**$ (86)**

Table of Contents

	Years Ended December 31,		
	2013	2012	Increase (Decrease)
Net operating revenues	100.0%	100.0%	—%
Operating expenses:			
Salaries, wages and benefits	48.4%	46.7%	1.7%
Supplies	16.1%	17.0%	(0.9)%
Other operating expenses, net	24.3%	23.5%	0.8%
Electronic health record incentives	(0.9)%	(0.4)%	(0.5)%
Depreciation and amortization	4.9%	4.7%	0.2%
Impairment of long-lived assets and goodwill, and restructuring charges	0.9%	0.2%	0.7%
Litigation and investigation costs	0.3%	0.1%	0.2%
Operating income	**6.0%**	**8.2%**	**(2.2)%**

Net operating revenues of our general hospitals include inpatient and outpatient revenues, as well as nonpatient revenues (rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) services provided by our Conifer subsidiary to third parties and (4) our recently acquired health plans. Revenues from our general hospitals represented approximately 90% and 95% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2013 and 2012, respectively.

Net operating revenues from our other operations were $1.186 billion and $468 million in the years ended December 31, 2013 and 2012, respectively. The increase in net operating revenues from other operations during 2013 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our recently acquired health plans and additional physician practices. Equity earnings for unconsolidated affiliates included in our net operating revenues from other operations were $15 million and $8 million for each of the years ended December 31, 2013 and 2012, respectively. Included in 2013 equity earnings of unconsolidated affiliates is $10 million of earnings associated with stepping up our basis in a previously held investment in an ambulatory surgery center in which we acquired a controlling interest and are now consolidating.

Selected Operating Statistics for All Continuing Operations Hospitals —The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the statistics from the 28 hospitals we acquired from Vanguard on October 1, 2013.

	Total Hospital Continuing Operations		
	Years Ended December 31,		
	2013	2012	Increase (Decrease)
Total admissions	558,726	506,485	10.3%
Adjusted patient admissions(1)	915,276	796,520	14.9%
Surgeries – inpatient	155,634	141,288	9.9%
Surgeries – outpatient	334,233	239,667	39.5%
Total surgeries	489,867	380,955	28.6%
Patient days – total	2,621,245	2,368,916	10.7%
Adjusted patient days(1)	4,243,334	3,693,218	14.9%
Average length of stay (days)	4.69	4.68	0.2%
Average licensed beds	14,963	13,187	13.5%
Utilization of licensed beds(3)	48.0%	49.1%	(1.1)%(2)
Total outpatient visits	5,074,606	4,167,114	21.8%
Net inpatient revenues	$ 6,952	$ 6,200	12.1%
Net outpatient revenues	$ 3,859	$ 3,167	21.9%
Net inpatient revenue per admission	$ 12,443	$ 12,241	1.7%
Net inpatient revenue per patient day	$ 2,652	$ 2,617	1.3%
Net outpatient revenue per visit	$ 760	$ 760	—%
Net patient revenue per adjusted admission	$ 11,812	$ 11,760	0.4%

Table of Contents

The tables below show certain selected historical operating statistics of our continuing hospitals on a same-hospital basis, where noted, and exclude the results of our acquisition of Vanguard effective October 1, 2013 because it has not been owned for more than one calendar year.

	Same-Hospital Continuing Operations		
	Years Ended December 31,		
Admissions, Patient Days and Surgeries	**2013**	**2012**	**Increase (Decrease)**
Total admissions	490,624	506,485	(3.1)%
Adjusted patient admissions(1)	787,995	796,520	(1.1)%
Paying admissions (excludes charity and uninsured)	455,550	470,756	(3.2)%
Charity and uninsured admissions	35,074	35,729	(1.8)%
Admissions through emergency department	308,200	312,902	(1.5)%
Paying admissions as a percentage of total admissions	92.9%	92.9%	—%(2)
Charity and uninsured admissions as a percentage of total admissions	7.1%	7.1%	—%(2)
Emergency department admissions as a percentage of total admissions	62.8%	61.8%	1.0%(2)
Surgeries – inpatient	136,713	141,288	(3.2)%
Surgeries – outpatient	303,500	239,667	26.6%
Total surgeries	440,213	380,955	15.6%
Patient days – total	2,315,304	2,368,916	(2.3)%
Adjusted patient days(1)	3,683,018	3,693,218	(0.3)%
Average length of stay (days)	4.72	4.68	0.9%
Number of hospitals (at end of period)	49	49	—(2)
Licensed beds (at end of period)	13,178	13,216	(0.3)%
Average licensed beds	13,180	13,187	(0.1)%
Utilization of licensed beds(3)	48.1%	49.1%	(1.0)%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the 2013 and 2012 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

	Same-Hospital Continuing Operations		
	Years Ended December 31,		
Outpatient Visits	**2013**	**2012**	**Increase (Decrease)**
Total visits	4,287,116	4,167,114	2.9%
Paying visits (excludes charity and uninsured)	3,834,195	3,728,402	2.8%
Charity and uninsured visits	452,921	438,712	3.2%
Emergency department visits	1,607,075	1,555,102	3.3%
Surgery visits	303,500	239,667	26.6%
Paying visits as a percentage of total visits	89.4%	89.5%	(0.1)%(1)
Charity and uninsured visits as a percentage of total visits	10.6%	10.5%	0.1%(1)

(1) The change is the difference between the 2013 and 2012 amounts shown.

	Same-Hospital Continuing Operations		
	Years Ended December 31,		
Revenues	**2013**	**2012**	**Increase (Decrease)**
Net operating revenues	$ 9,688	$ 9,119	6.2%
Revenues from the uninsured	$ 671	$ 636	5.5%
Net inpatient revenues(1)	$ 6,101	$ 6,200	(1.6)%
Net outpatient revenues(1)	$ 3,366	$ 3,167	6.3%

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $279 million and $269 million for the years ended December 31, 2013 and 2012, respectively. Net outpatient revenues include self-pay revenues of $392 million and $367 million for the years ended December 31, 2013 and 2012, respectively.

Table of Contents

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2013	2012	Increase (Decrease)
Net inpatient revenue per admission	$ 12,435	$ 12,241	1.6%
Net inpatient revenue per patient day	$ 2,635	$ 2,617	0.7%
Net outpatient revenue per visit	$ 785	$ 760	3.3%
Net patient revenue per adjusted patient admission(1)	$ 12,014	$ 11,760	2.2%
Net patient revenue per adjusted patient day(1)	$ 2,570	$ 2,536	1.3%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2013	2012	Increase (Decrease)
Provision for doubtful accounts	$ 829	$ 785	5.6%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.9%	7.9%	—%(1)
Collection rate on self-pay accounts(2)	28.7%	28.9%	(0.2)%(1)
Collection rate on commercial managed care accounts	98.3%	98.0%	0.3%(1)

(1) The change is the difference between the 2013 and 2012 amounts shown.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

Table of Contents

Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2013	2012	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 4,142	$ 3,983	4.0%
Supplies	1,555	1,552	0.2%
Other operating expenses	2,093	2,040	2.6%
Total	$ 7,790	$ 7,575	2.8%
Conifer			
Salaries, wages and benefits	$ 576	$ 274	110.2%
Other operating expenses	211	107	97.2%
Total	$ 787	$ 381	106.6%
Total			
Salaries, wages and benefits	$ 4,718	$ 4,257	10.8%
Supplies	1,555	1,552	0.2%
Other operating expenses	2,304	2,147	7.3%
Total	$ 8,577	$ 7,956	7.8%
Rent/lease expense(1)			
Hospital Operations and other	$ 153	$ 144	6.3%
Conifer	14	12	16.7%
Total	$ 167	$ 156	7.1%
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,124	$ 1,078	4.3%
Supplies per adjusted patient day	422	420	0.5%
Other operating expenses per adjusted patient day	561	553	1.4%
Total per adjusted patient day	$ 2,107	$ 2,051	2.7%
Salaries, wages and benefits per adjusted patient admission	$ 5,253	$ 5,001	5.0%
Supplies per adjusted patient admission	1,973	1,948	1.3%
Other operating expenses per adjusted patient admission	2,622	2,561	2.4%
Total per adjusted patient admission	$ 9,848	$ 9,510	3.6%

(1) Included in other operating expenses.

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

REVENUES

During the year ended December 31, 2013, same-hospital net operating revenues before provision for doubtful accounts increased 6.2%, compared to the year ended December 31, 2012, primarily due to improved terms of our managed care contracts, an increase in outpatient volumes and an increase in our other operations revenues, partially offset by a decrease in inpatient volumes and the impact of a $81 million favorable adjustment in the 2012 period from the industry-wide settlement (the "Medicare Budget Neutrality settlement") that corrected Medicare payments made to providers for inpatient hospital services for a number of prior periods.

Our same-hospital net outpatient revenues and total outpatient visits increased 6.3% and 2.9%, respectively, during the year ended December, 31 2013 compared to the year ended December 31, 2012. Outpatient revenues and volume growth was primarily driven by improved terms of our managed care contracts, increased outpatient volume levels and our outpatient acquisition program. Net outpatient revenue per visit increased 3.3% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $919 million and $488 million for the year ended December 31, 2013 and 2012, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to the 10-year CHI agreement entered into in May 2012, expanded service offerings and two acquisitions in the three months ended December 31, 2012.

Table of Contents

Same-hospital patient days decreased by 2.3% during the year ended December 31, 2013 compared to the year ended December 31, 2012. We believe the following factors contributed to the changes in our inpatient volume levels: (1) the current weak economic conditions, which we believe have adversely impacted the level of elective procedures performed at our hospitals; (2) loss of patients to competing health care providers; (3) an increase in patients with high-deductible health insurance plans; and (4) industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than in an inpatient setting.

PROVISION FOR DOUBTFUL ACCOUNTS

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.1% for the year ended December 31, 2013 compared to 7.9% for the year ended December 31, 2012. The 5.6% increase in the absolute amount of provision for doubtful accounts in the 2013 period compared to the 2012 period was primarily due to a 5.5% increase in uninsured patient revenues, as well as higher patient co-pays and deductibles for our same-hospitals. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2013 and December 31, 2012:

	December 31, 2013			December 31, 2012		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 309	$ —	$ 309	$ 172	$ —	$ 172
Medicaid	141	—	141	116	—	116
Net cost report settlements payable and valuation allowances	(4)	—	(4)	(24)	—	(24)
Managed care	1,240	69	1,171	769	72	697
Self-pay uninsured	344	290	54	204	178	26
Self-pay balance after insurance	224	141	83	143	78	65
Estimated future recoveries from accounts assigned to our Conifer subsidiary	91	—	91	88	—	88
Other payers	279	89	190	264	68	196
Total continuing operations	2,624	589	2,035	1,732	396	1,336
Total discontinued operations	3	—	3	14	5	9
	$ 2,627	**$ 589**	**$ 2,038**	**$ 1,746**	**$ 401**	**$ 1,345**

We provide revenue cycle management and patient communications services, among others, through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have increased our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology, and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years, as we have experienced adverse changes in our business mix. At December 31, 2013, our same-hospital collection rate on self-pay accounts was approximately 28.7%. Our recent same-hospital self-pay collection rates were as follows: 27.9% at March 31, 2012; 28.5% at June 30, 2012; 28.8% at September 30, 2012; 28.9% at December 31, 2012; 28.8% at March 31, 2013; 28.7% at June 30, 2013; and 28.8% at September 30, 2013. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2013, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million.

Table of Contents

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated same-hospital collection rate from managed care payers was approximately 98.3% at December 31, 2013 and 98.0% at December 31, 2012.

Conifer continues to focus on revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collection at point-of-service, and financial counseling. The goals of the effort are focused on reducing denials, improving service levels to patients and increasing the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) accounts receivable days outstanding ("AR Days"), and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from continuing operations of $2.039 billion and $1.360 billion at December 31, 2013 and 2012, respectively, excluding cost report settlements payable and valuation allowances of $4 million and $24 million at December 31, 2013 and 2012, respectively:

	December 31, 2013				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	76%	58%	73%	32%	65%
61-120 days	9%	21%	13%	17%	14%
121-180 days	4%	9%	5%	7%	6%
Over 180 days	11%	12%	9%	44%	15%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

	December 31, 2012				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	92%	62%	78%	29%	67%
61-120 days	2%	19%	11%	17%	12%
121-180 days	1%	8%	4%	9%	5%
Over 180 days	5%	11%	7%	45%	16%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Our AR Days from continuing operations were 48.3 days at December 31, 2013 and 52.7 days at December 31, 2012, respectively, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2013, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $3.3 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medical Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. At the present time our new acquisitions are not part of this program. Based on recent trends, approximately 93% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts

receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2013 and 2012 by aging category:

	December 31,	
	2013	2012
0-60 days	$ 132	$ 99
61-120 days	28	22
121-180 days	8	5
Over 180 days	18	16
Total	**$ 186**	**$ 142**

SALARIES, WAGES AND BENEFITS

Salaries, wages and benefits expense as a percentage of net operating revenues increased 1.7% for the year ended December 31, 2013 compared to the year ended December 31, 2012. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 5.0% in the year ended December 31, 2013 compared to the same period in 2012. This increase is primarily due to an increase in the number of physicians we employ, annual merit increases for certain of our employees, increased health benefits costs and increased contract labor, partially offset by a decrease in incentive compensation expense. Salaries, wages and benefits expense for the year ended December 31, 2013 and 2012 included stock-based compensation expense of $37 million and $32 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $302 million in the year ended December 31, 2013 compared to the year ended December 31, 2012 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the new CHI partnership, the Vanguard acquisition and Conifer's two acquisitions in the three months ended December 31, 2012.

As of December 31, 2013, approximately 21% of our employees were represented by various labor unions. These employees — primarily registered nurses and service and maintenance workers — were located at 39 of our hospitals, the majority of which are in California, Florida, Massachusetts and Michigan. We currently have two expired contracts and are negotiating renewals under extension agreements. We are also negotiating an initial contract at one of our hospitals where employees recently chose union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2014.

SUPPLIES

Supplies expense as a percentage of net operating revenues decreased 0.9% for the year ended December 31, 2013 compared to the year ended December 31, 2012. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 1.3% in the year ended December 31, 2013 compared to the same period in 2012. Supplies expense was favorably impacted by lower implant costs, orthopedic supply costs and cardiology supply costs due to renegotiated prices, partially offset by increased costs of pharmaceuticals and increased surgical supply costs as a result of higher surgical volumes.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, bulk purchases and operational improvements. The items of current cost reduction focus continue to be cardiac stents and pacemakers, orthopedics and implants, and high-cost pharmaceuticals. We also utilize group-purchasing strategies and supplies-management services in an effort to reduce costs.

Table of Contents

OTHER OPERATING EXPENSES, NET

Other operating expenses as a percentage of net operating revenues was 24.3% in the year ended December 31, 2013 compared to 23.5% in the year ended December 31, 2012. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 2.4% in the year ended December 31, 2013 compared to the same period in 2012. The 2.6% increase in same-hospital other operating expenses in the year ended December 31, 2013 compared to the year ended December 31, 2012 is primarily due to:

- increased costs of contracted services ($92 million) primarily related to Conifer's new clients and business acquisitions;
- increased medical fees primarily related to employed physicians ($42 million);
- increased rent and lease expenses ($6 million); and
- increased malpractice expense ($6 million).

These increases were partially offset by lower consulting and legal expenses ($25 million) in part due to the aforementioned Medicare Budget Neutrality settlement in 2012.

Malpractice expense in the year ended December 31, 2013 included favorable adjustments totaling approximately $11 million due to a 127 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of $2 million due to a 17 basis point decrease in the interest rate in the 2012 period.

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment continues to decline. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination costs, and $59 million in acquisition-related costs, which includes both transaction costs and acquisition integration charges.

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of $19 million, consisting of $3 million relating to the impairment of obsolete assets, $2 million relating to other impairment charges, $8 million of employee severance costs and $6 million of other related costs.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges.

Table of Contents

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the year ended December 31, 2013 and 2012 were $31 million and $5 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2013 was $474 million compared to $412 million for the year ended December 31, 2012, primarily due to increased borrowings partially offset by a lower average interest rate on our outstanding debt.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2013, we recorded a loss from early extinguishment of debt of $348 million consisting of $177 million related to the difference between the purchase prices and the par values of the $714 million aggregate principal amount of our 10% senior secured notes due 2018 that we purchased and called during the period, as well as the write-off of unamortized note discounts and issuance costs, and $171 million related to the difference between the purchase prices and the par values of the $925 million aggregate principal amount of our 8 $^{7}/_{8}$% senior secured notes due 2019 that we purchased and called during the period, as well as the write-off of unamortized note discounts and issuance costs.

INCOME TAX EXPENSE

During the year ended December 31, 2013, we recorded an income tax benefit of $65 million, primarily related to the loss from early extinguishment of debt, compared to an expense of $125 million during the year ended December 31, 2012.

DISCONTINUED OPERATIONS: IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL, AND RESTRUCTURING CHARGES

During the year ended December 31, 2012, we recorded an impairment charge in discontinued operations of $100 million related to the sale of Creighton University Medical Center, consisting of $98 million for the write-down of long-lived assets to their estimated fair values and a $2 million charge for the write-down of goodwill.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

The financial information provided throughout this report, including our Condensed Consolidated Financial Statements and the notes thereto, has been prepared in conformity with accounting principles generally accepted in the United States of America (“GAAP”). However, we use certain non-GAAP financial measures defined below in communications with investors, analysts, rating agencies, banks and others to assist such parties in understanding the impact of various items on our financial statements, some of which are recurring or involve cash payments. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

“Adjusted EBITDA” is a non-GAAP measure that we use in our analysis of the performance of our business, which we define as net income (loss) attributable to our common shareholders before: (1) the cumulative effect of changes in accounting principle, net of tax; (2) net loss (income) attributable to noncontrolling interests; (3) preferred stock dividends; (4) income (loss) from discontinued operations, net of tax; (5) income tax benefit (expense); (6) investment earnings (loss); (7) gain (loss) from early extinguishment of debt; (8) net gain (loss) on sales of investments; (9) interest expense; (10) litigation and investigation benefit (costs), net of insurance recoveries; (11) hurricane insurance recoveries, net of costs; (12) impairment and restructuring charges and acquisition-related costs; and (13) depreciation and amortization. As is the case with all non-GAAP measures, investors should consider the limitations associated with this metric, including the potential lack of comparability of this measure from one company to another, and should recognize that Adjusted EBITDA does not provide a complete measure of our operating performance because it excludes many items that are included in our financial statements. Accordingly, investors are encouraged to use GAAP measures when evaluating our financial performance.

Table of Contents

The table below shows the reconciliation of Adjusted EBITDA to net income attributable to our common shareholders (the most comparable GAAP term) for the years ended December 31, 2013 and 2012:

	Years Ended December 31,	
	2013	2012
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ (134)	$ 141
Less: Net loss (income) attributable to noncontrolling interests	(30)	19
Preferred stock dividends	—	(11)
Loss from discontinued operations, net of tax	(11)	(76)
Income (loss) from continuing operations	(93)	209
Income tax benefit (expense)	65	(125)
Investment earnings	1	1
Loss from early extinguishment of debt	(348)	(4)
Interest expense	(474)	(412)
Operating income	663	749
Litigation and investigation costs	(31)	(5)
Impairment and restructuring charges, and acquisition-related costs	(103)	(19)
Depreciation and amortization	(545)	(430)
Adjusted EBITDA	**$ 1,342**	**$ 1,203**
Net operating revenues	**$ 11,102**	**$ 9,119**
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	**12.1%**	**13.2%**

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2012 COMPARED TO THE YEAR ENDED DECEMBER 31, 2011

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2012 and 2011:

	Years Ended December 31,		
	2012	2011	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 9,436	$ 9,061	$ 375
Other operations	468	310	158
Net operating revenues before provision for doubtful accounts	9,904	9,371	533
Less provision for doubtful accounts	785	717	68
Net operating revenues	**9,119**	**8,654**	**465**
Operating expenses:			
Salaries, wages and benefits	4,257	4,015	242
Supplies	1,552	1,548	4
Other operating expenses, net	2,147	2,020	127
Electronic health record incentives	(40)	(55)	15
Depreciation and amortization	430	398	32
Impairment of long-lived assets and goodwill, and restructuring charges	19	20	(1)
Litigation and investigation costs	5	55	(50)
Operating income	**$ 749**	**$ 653**	**$ 96**

Table of Contents

	Years Ended December 31,		
	2012	2011	Increase (Decrease)
Net operating revenues	100.0%	100.0%	—%
Operating expenses:			
Salaries, wages and benefits	46.7%	46.4%	0.3%
Supplies	17.0%	17.9%	(0.9)%
Other operating expenses, net	23.5%	23.4%	0.1%
Electronic health record incentives	(0.4)%	(0.6)%	0.2%
Depreciation and amortization	4.7%	4.6%	0.1%
Impairment of long-lived assets and goodwill, and restructuring charges	0.2%	0.2%	—%
Litigation and investigation costs	0.1%	0.6%	(0.5)%
Operating income	**8.2%**	**7.5%**	**0.7%**

Revenues from our general hospitals represented approximately 95% and 97% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2012 and 2011, respectively.

Net operating revenues from our other operations were $468 million and $310 million in the years ended December 31, 2012 and 2011, respectively. The increase in net operating revenues from other operations during 2012 primarily relates to our additional owned physician practices and revenue cycle services provided by our Conifer subsidiary. Equity earnings for unconsolidated affiliates included in our net operating revenues from other operations were $8 million for each of the years ended December 31, 2012 and 2011.

The tables below show certain selected historical operating statistics of our continuing hospitals on a same-hospital basis. We have excluded statistics related to hospitals previously owned by Vanguard from the same-hospital statistics for the years ended December 31, 2012 and 2011 because we did not own those hospitals during those years.

	Same-Hospital Continuing Operations		
	Years Ended December 31,		
Admissions, Patient Days and Surgeries	2012	2011	Increase (Decrease)
Total admissions	506,485	507,834	(0.3)%
Adjusted patient admissions(1)	796,520	779,833	2.1%
Paying admissions (excludes charity and uninsured)	470,756	473,943	(0.7)%
Charity and uninsured admissions	35,729	33,891	5.4%
Admissions through emergency department	312,902	306,424	2.1%
Paying admissions as a percentage of total admissions	92.9%	93.3%	(0.4)%(2)
Charity and uninsured admissions as a percentage of total admissions	7.1%	6.7%	0.4%(2)
Emergency department admissions as a percentage of total admissions	61.8%	60.3%	1.5%(2)
Surgeries – inpatient	141,288	144,665	(2.3)%
Surgeries – outpatient	239,667	217,621	10.1%
Total surgeries	380,955	362,286	5.2%
Patient days – total	2,368,916	2,413,245	(1.8)%
Adjusted patient days(1)	3,693,218	3,673,441	0.5%
Average length of stay (days)	4.68	4.75	(1.5)%
Number of hospitals (at end of period)	49	49	—(2)
Licensed beds (at end of period)	13,216	13,119	0.7%
Average licensed beds	13,187	13,115	0.5%
Utilization of licensed beds(3)	49.1%	50.4%	(1.3)%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(2) The change is the difference between the 2012 and 2011 amounts shown.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Table of Contents

Outpatient Visits	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Total visits	4,167,114	3,954,016	5.4%
Paying visits (excludes charity and uninsured)	3,728,402	3,554,231	4.9%
Charity and uninsured visits	438,712	399,785	9.7%
Emergency department visits	1,555,102	1,457,250	6.7%
Surgery visits	239,667	217,621	10.1%
Paying visits as a percentage of total visits	89.5%	89.9%	(0.4)%(1)
Charity and uninsured visits as a percentage of total visits	10.5%	10.1%	0.4%(1)

(2) The change is the difference between the 2012 and 2011 amounts shown.

Revenues	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Net operating revenues	$ 9,119	$ 8,654	5.4%
Revenues from the uninsured	$ 636	$ 607	4.8%
Net inpatient revenues(1)	$ 6,200	$ 6,028	2.9%
Net outpatient revenues(1)	$ 3,167	$ 2,928	8.2%

(2) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $269 million and $271 million for the years ended December 31, 2012 and 2011, respectively. Net outpatient revenues include self-pay revenues of $367 million and $336 million for the years ended December 31, 2012 and 2011, respectively.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Net inpatient revenue per admission	$ 12,241	$ 11,870	3.1%
Net inpatient revenue per patient day	$ 2,617	$ 2,498	4.8%
Net outpatient revenue per visit	$ 760	$ 741	2.6%
Net patient revenue per adjusted patient admission(1)	$ 11,760	$ 11,485	2.4%
Net patient revenue per adjusted patient day(1)	$ 2,536	$ 2,438	4.0%

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Provision for doubtful accounts	$ 785	$ 717	9.5%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.9%	7.7%	0.2%(1)
Collection rate on self-pay accounts(2)	28.9%	27.7%	1.2%(1)
Collection rate on commercial managed care accounts	98.0%	98.2%	(0.2)%(1)

(1) The change is the difference between the 2012 and 2011 amounts shown.
(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

Table of Contents

Selected Operating Expenses	Same-Hospital Continuing Operations Years Ended December 31, 2012	2011	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 3,983	$ 3,792	5.0%
Supplies	1,552	1,548	0.3%
Other operating expenses	2,040	1,946	4.8%
Total	$ 7,575	$ 7,286	4.0%
Conifer			
Salaries, wages and benefits	$ 274	$ 223	22.9%
Other operating expenses	107	74	44.6%
Total	$ 381	$ 297	28.3%
Total			
Salaries, wages and benefits	$ 4,257	$ 4,015	6.0%
Supplies	1,552	1,548	0.3%
Other operating expenses	2,147	2,020	6.3%
Total	$ 7,956	$ 7,583	4.9%
Rent/lease expense(1)			
Hospital Operations and other	$ 144	$ 132	9.1%
Conifer	12	11	9.1%
Total	$ 156	$ 143	9.1%
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,078	$ 1,032	4.5%
Supplies per adjusted patient day	420	421	(0.2)%
Other operating expenses per adjusted patient day	553	530	4.3%
Total per adjusted patient day	$ 2,051	$ 1,983	3.4%
Salaries, wages and benefits per adjusted patient admission	$ 5,001	$ 4,863	2.8%
Supplies per adjusted patient admission	1,948	1,985	(1.9)%
Other operating expenses per adjusted patient admission	2,561	2,495	2.6%
Total per adjusted patient admission	$ 9,510	$ 9,343	1.8%

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

REVENUES

During the year ended December 31, 2012, net operating revenues before provision for doubtful accounts increased 5.7%, which included a 4.6% increase in net patient revenues, compared to the year ended December 31, 2011. Increases in pricing were the largest contributing factors, resulting in a 4.0% increase in net patient revenues, while increases in our overall volumes resulted in a 0.6% increase in net patient revenues.

Our same-hospital net inpatient revenues for the year ended December 31, 2012 increased by 2.9% compared to the year ended December, 31, 2011. Several factors impacted our net inpatient revenues in the 2012 period compared to the 2011 period, including:

- Improved managed care pricing as a result of renegotiated contracts;
- Medicaid DSH and other state-funded subsidy revenues of $283 million in the year ended December 31, 2012 compared to $255 million in the year ended December 31, 2011;
- Favorable adjustments of approximately $81 million in the year ended December 31, 2012 related to the aforementioned Medicare Budget Neutrality settlement; and
- An unfavorable shift in our total payer mix.

Patient days decreased by 1.8% and total admissions decreased by 0.3% during the year ended December 31, 2012 compared to the year ended December 31, 2011. We believe the following factors contributed to the changes in our inpatient volume levels: (1) weak economic conditions, which we believe adversely impacted the level of elective procedures performed at our hospitals; (2) loss of patients to competing health care providers; and (3) industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than in an inpatient setting.

Same-hospital net outpatient revenues and total outpatient visits increased 8.2% and 5.4%, respectively, during the year ended December 31, 2012 compared to the year ended December 31, 2011. The growth in our outpatient revenues and volumes was related to both organic growth and growth from acquisitions. Net outpatient revenue per visit increased 2.6% primarily due to the improved terms of our managed care contracts, partially offset by the provision of lower acuity services by outpatient centers we acquired in the past several years, as well as an unfavorable shift in our total outpatient payer mix.

Our Conifer subsidiary generated net operating revenues of $488 million and $340 million for the years ended December 31, 2012 and 2011, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients, expanded service offerings and acquisitions.

PROVISION FOR DOUBTFUL ACCOUNTS

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.9% for the year ended December 31, 2012 compared to 7.7% for the year ended December 31, 2011. The increase in provision for doubtful accounts primarily related to increased uninsured patient volumes, partially offset by the impact of a 120 basis point improvement in our collection rate on self-pay accounts.

The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2012 and 2011:

	December 31, 2012			December 31, 2011		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 172	$ —	$ 172	$ 166	$ —	$ 166
Medicaid	116	—	116	118	—	118
Net cost report settlements payable and valuation allowances	(24)	—	(24)	(39)	—	(39)
Managed care	769	72	697	760	67	693
Self-pay uninsured	204	178	26	215	190	25
Self-pay balance after insurance	143	78	65	134	77	57
Estimated future recoveries from accounts assigned to our Conifer subsidiary	88	—	88	62	—	62
Other payers	264	68	196	212	48	164
Total continuing operations	1,732	396	1,336	1,628	382	1,246
Total discontinued operations	14	5	9	47	15	32
	$ 1,746	**$ 401**	**$ 1,345**	**$ 1,675**	**$ 397**	**$ 1,278**

At December 31, 2012, our collection rate on self-pay accounts was approximately 28.9%. We experienced a relatively stable self-pay collection rate during 2011 and 2012 as follows: 27.8% at March 31, 2011; 27.9% at June 30, 2011; 27.7% at both September 30, 2011 and December 31, 2011; 27.9% at March 31, 2012; 28.5% at June 30, 2012; and 28.8% at September 30, 2012. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2012, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $7 million.

Table of Contents

Our estimated collection rate from managed care payers was approximately 98.0% at December 31, 2012 and 98.2% at December 31, 2011.

The following tables present the approximate aging by payer of our net accounts receivable from continuing operations of $1.360 billion and $1.285 billion at December 31, 2012 and 2011, respectively, excluding cost report settlements payable and valuation allowances of $24 million and $39 million at December 31, 2012 and 2011, respectively:

	December 31, 2012				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	92%	62%	78%	29%	67%
61-120 days	2%	19%	11%	17%	12%
121-180 days	1%	8%	4%	9%	5%
Over 180 days	5%	11%	7%	45%	16%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

	December 31, 2011				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	93%	63%	75%	31%	68%
61-120 days	3%	18%	12%	17%	12%
121-180 days	2%	9%	5%	10%	6%
Over 180 days	2%	10%	8%	42%	14%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Our AR Days from continuing operations were 53 days at both December 31, 2012 and 2011, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of December 31, 2012, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $3.2 billion related to our continuing operations. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2012 and 2011 by aging category:

	December 31,	
	2012	2011
0-60 days	$ 99	$ 82
61-120 days	22	18
121-180 days	5	7
Over 180 days	16	15
Total	**$ 142**	**$ 122**

SALARIES, WAGES AND BENEFITS

Salaries, wages and benefits expense as a percentage of net operating revenues increased 0.3% for the year ended December 31, 2012 compared to the year ended December 31, 2011. Salaries, wages and benefits per adjusted patient admission increased 2.8% in the year ended December 31, 2012 compared to the same period in 2011. This increase is primarily due to an increase in the number of physicians we employ, annual merit and contractual wage increases for our employees, increased contract labor costs, increased annual incentive compensation expense, increased workers' compensation expense, increased health benefits costs and increased employee-related costs associated with our HIT implementation program,

partially offset by decreased overtime expense. Included in salaries, wages and benefits expense in 2012 is $1 million of expense due to a 17 basis point decrease in the interest rate used to estimate the discounted present value of projected future workers' compensation liabilities, compared to a $4 million unfavorable adjustment as a result of a 136 basis point decrease in the interest rate in the year ended December 31, 2011. Salaries, wages and benefits expense for the years ended December 31, 2012 and 2011 also included stock-based compensation expense of $32 million and $24 million, respectively.

Salaries, wages and benefits expense for our Conifer segment increased by 22.9% in the year ended December 31, 2012 compared to the year ended December 31, 2011 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the new CHI partnership and Conifer's two acquisitions in 2012.

SUPPLIES

Supplies expense as a percentage of net operating revenues decreased 0.9% for the year ended December 31, 2012 compared to the year ended December 31, 2011. Supplies expense per adjusted patient admission decreased 1.9% in the year ended December 31, 2012 compared to the same period in 2011. Supplies expense was favorably impacted by lower pharmaceutical costs and a decline in orthopedic and cardiology-related costs due to renegotiated prices, partially offset by increased costs of implants and surgical supplies. In general, supplies expense changes are primarily attributable to changes in our patient volume levels and the mix of procedures performed.

OTHER OPERATING EXPENSES, NET

Other operating expenses as a percentage of net operating revenues was 23.5% in the year ended December 31, 2012 compared to 23.4% in the year ended December 31, 2011. Other operating expenses per adjusted patient admission increased by 2.6% in the year ended December 31, 2012 compared to the same period in 2011. The increase in other operating expenses for our Hospital Operations and other segment is primarily due to:

- increased costs of contracted services ($33 million), primarily due to additional physician practices we acquired;
- higher consulting and legal costs of $23 million, which includes costs related to the aforementioned Medicare Budget Neutrality settlement and various managed care payer settlements;
- increased systems implementation costs ($17 million), primarily related to our HIT implementation program;
- increased rent and lease expenses ($14 million);
- $13 million of costs associated with funding indigent care services by certain of our Texas hospitals beginning in the three months ended December 31, 2012; and
- gains totaling $4 million from the sale of land and buildings in the 2012 period compared to gains of $8 million from the sale of a building at the former campus of one of our hospitals and a medical office building in the 2011 period.

These increases were partially offset by decreased physician relocation expenses ($9 million).

Malpractice expense was $92 million in the year ended December 31, 2012, which included an unfavorable adjustment of approximately $2 million due to a 17 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities, compared to malpractice expense of $108 million in the year ended December 31, 2011, which included an unfavorable adjustment of approximately $17 million due to a 136 basis point decrease in the interest rate. The amount of malpractice expense in the year ended December 31, 2012 may not necessarily be indicative of malpractice expense amounts in future years due to changes in loss experience and interest rates used to estimate the discounted present value of projected future malpractice liabilities.

Other operating expenses for our Conifer segment increased by 44.6% in the year ended December 31, 2012 compared to the year ended December 31, 2011 primarily due to additional operating expenses related to the new CHI partnership and Conifer's two acquisitions in 2012.

Table of Contents

IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL, AND RESTRUCTURING CHARGES

During the year ended December 31, 2012, we recorded net impairment and restructuring charges of $19 million, consisting of $3 million relating to the impairment of obsolete assets, $2 million relating to other impairment charges, $8 million of employee severance costs and $6 million of other related costs.

During the year ended December 31, 2011, we recorded net impairment and restructuring charges of $20 million. This amount included a $6 million impairment charge for the write-down of buildings and equipment of one of our previously impaired hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our estimates of future undiscounted cash flows of the hospital at that time, consistent with our previous estimates in prior years when impairment charges were recorded at this hospital, indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believed the most significant factors contributing to the adverse financial trends at that time included reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $20 million as of December 31, 2011 after recording the impairment charge. In addition, we recorded impairment charges of $1 million in connection with the sale of seven medical office buildings in Texas, $1 million related to a cost basis investment, $7 million in employee severance costs, $3 million in lease termination costs, $1 million of acceleration of stock-based compensation costs and $1 million of other related costs.

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the year ended December 31, 2012 were $5 million compared to $55 million for the year ended December 31, 2011. The 2012 amount primarily related to costs associated with various legal proceedings and governmental reviews. The 2011 amount primarily related to costs associated with our evaluation of an unsolicited acquisition proposal received in November 2010 (which was subsequently withdrawn), changes in reserve estimates established in connection with certain governmental reviews, accruals for a physician privileges case and certain hospital-related tort claims, the settlement of a union arbitration claim and costs to defend various matters.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2012 was $412 million compared to $375 million for the year ended December 31, 2011. The increase primarily related to a $30 million favorable impact from an interest rate swap agreement we terminated in August 2011. During the year ended December 31, 2011, the interest rate swap agreement generated approximately $8 million of cash interest savings and a $22 million gain on the settlement of the agreement. See Note 6 to the accompanying Consolidated Financial Statements for additional information about this agreement.

LOSS FROM EARLY EXTINGUISHMENT OF DEBT

During the year ended December 31, 2012, we recorded a loss from early extinguishment of debt of approximately $4 million, primarily related to the difference between the purchase prices and the par values of the $161 million aggregate principal amount outstanding of our 7 ⅜% senior notes due 2013 that we purchased during the period. During the year ended December 31, 2011, we recorded a loss from early extinguishment of debt of approximately $117 million, primarily related to the difference between the purchase prices and the par values of the $713 million aggregate principal amount of 9% senior secured notes due 2015 that we purchased during the period, as well as the write-off of unamortized note discounts and issuance costs.

INCOME TAX EXPENSE

During the year ended December 31, 2012, we recorded income tax expense of $125 million compared to $61 million during the year ended December 31, 2011. See Note 16 to the accompanying Consolidated Financial Statements for additional information about income taxes.

Table of Contents

DISCONTINUED OPERATIONS: IMPAIRMENT OF LONG-LIVED ASSETS AND GOODWILL, AND RESTRUCTURING CHARGES

During the year ended December 31, 2012, we recorded an impairment charge in discontinued operations of $100 million related to the sale of Creighton University Medical Center, consisting of $98 million for the write-down of long-lived assets to their estimated fair values and a $2 million charge for the write-down of goodwill.

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

Our obligations to make future cash payments under contracts, such as debt and lease agreements, and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, are summarized in the table below, all as of December 31, 2013:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
				(In Millions)			
Long-term debt(1)	$ 15,449	$ 736	$ 1,114	$ 1,023	$ 618	$ 1,659	$ 10,299
Capital lease obligations(1)	408	88	65	25	49	5	176
Long-term non-cancelable operating leases	663	137	117	102	80	56	171
Standby letters of credit	189	189	—	—	—	—	—
Guarantees(2)	126	74	30	17	5	—	—
Asset retirement obligations	142	—	—	—	—	—	142
Academic affiliation agreements(3)	209	44	29	29	29	17	61
Tax liabilities	29	—	—	—	—	—	29
Defined benefit plan obligations	553	28	20	20	20	20	445
Construction and capital improvements	466	190	150	63	63	—	—
Information technology contract services	1,364	227	164	167	169	172	465
Purchase orders	421	421	—	—	—	—	—
Total(4)	**$ 20,019**	**$ 2,134**	**$ 1,689**	**$ 1,446**	**$ 1,033**	**$ 1,929**	**$ 11,788**

(1) Includes interest through maturity date/lease termination.
(2) Includes minimum revenue guarantees, primarily related to physicians under relocation agreements and physician groups that provide services at our hospitals, and operating lease guarantees.
(3) These agreements contain various rights and termination provisions.
(4) Professional liability and workers' compensation reserves have been excluded from the table. At December 31, 2013, the current and long-term professional and general liability reserves included in our Consolidated Balance Sheet were approximately $156 million and $543 million, respectively, and the current and long-term workers' compensation reserves included in our Consolidated Balance Sheet were approximately $55 million and $179 million, respectively.

Standby letters of credit are required principally by our insurers and various states to collateralize our workers' compensation programs pursuant to statutory requirements and as security to collateralize the deductible and self-insured retentions under certain of our professional and general liability insurance programs. The amount of collateral required is primarily dependent upon the level of claims activity and our creditworthiness. The insurers require the collateral in case we are unable to meet our obligations to claimants within the deductible or self-insured retention layers. The standby letters of credit are issued under our revolving credit facility, as amended November 29, 2011.

We consummated the following transactions affecting our long-term commitments in the year ended December 31, 2013:

- On October 1, 2013, we entered into supplemental indentures relating to the sale of $2.8 billion aggregate principal amount of 8 1/8% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. Interest payments for the life of these notes will be approximately $2.7 billion. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard, which closed on October 1, 2013. As part of the acquisition, we assumed Vanguard's cash obligations, including a capital expenditure commitment at Detroit Medical Center and remaining construction costs for a new hospital campus in New Braunfels, Texas and significant expansion at two hospitals, for a total of approximately $600 million.

Table of Contents

- Following our acquisition of Vanguard, in accordance with the terms of our Credit Agreement, on October 15, 2013, we increased the maximum aggregate principal amount of our revolving credit facility from $800 million to $1 billion, subject to borrowing availability.

- We entered into non-cancellable capital leases of approximately $341 million, primarily for equipment and three hospitals we previously leased under operating lease agreements.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our cash and our operating results. At December 31, 2013, using the last 12 months of Adjusted EBITDA, including Vanguard's last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 6.0x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including acquisitions that involve the assumption of long-term debt. We intend to manage this ratio by following our business plan, managing our cost structure and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections in Part I of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements. Capital expenditures were $691 million, $508 million and $475 million in the years ended December 31, 2013, 2012 and 2011, respectively, which included $2 million and $8 million in the years ended December 31, 2012 and 2011, respectively, related to discontinued operations. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2014 will total approximately $900 million to $1 billion, including $193 million that was accrued as a liability at December 31, 2013. Our budgeted 2014 capital expenditures include approximately $18 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree. We expect to spend approximately $13 million more on such improvements over the next two years.

During the year ended December 31, 2013, we acquired Vanguard for approximately $4.3 billion, or $21.00 per share of Vanguard stock, including the assumption of $2.5 billion of net Vanguard debt. We also purchased the following businesses: (1) 11 ambulatory surgery centers (in one of which we had previously held a noncontrolling interest); (2) an urgent care center; (3) a provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals; (4) a medical office building; and (5) various physician practice entities. The fair value of the consideration conveyed in the acquisitions was $1.515 billion.

Interest payments, net of capitalized interest, were $426 million, $376 million and $347 million in the years ended December 31, 2013, 2012 and 2011, respectively.

From time to time, we use interest rate swap agreements to manage our exposure to future changes in interest rates. We were party to an interest rate swap agreement for an aggregate notional amount of $600 million from February 14, 2011 through August 2, 2011. The interest rate swap agreement was designated as a fair value hedge. It had the effect of converting our 10% senior secured notes due 2018 from a fixed interest rate paid semi-annually to a variable interest rate paid semi-annually based on the six-month London Interbank Offered Rate plus a floating rate spread of 6.60%. During the term of the interest rate swap agreement, changes in the fair value of the interest rate swap agreement and changes in the fair value of the 10% senior secured notes were recorded in interest expense. During the year ended December 31, 2011, our interest rate swap agreement generated $8 million of cash interest savings and a $22 million gain on the settlement of the agreement.

Table of Contents

Income tax payments, net of tax refunds, were approximately $6 million in the year ended December 31, 2013 compared to approximately $13 million in the year ended December 31, 2012. At December 31, 2013, our carryforwards available to offset future taxable income consisted of (1) federal net operating loss ("NOL") carryforwards of approximately $1.6 billion pretax expiring in 2024 to 2033, (2) approximately $19 million in alternative minimum tax credits with no expiration, (3) general business credit carryforwards of approximately $14 million expiring in 2023 to 2031, and (4) state NOL carryforwards of $3.8 billion expiring in 2014 to 2033 for which the associated deferred tax benefit, net of valuation allowance and federal tax impact, is $34 million. Our ability to utilize NOL carryforwards to reduce future taxable income may be limited under Section 382 of the Internal Revenue Code if our "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership by more than 50 percentage points (by value) over a rolling three-year period. These ownership changes include purchases of common stock under share repurchase programs, our offering of stock, the purchase or sale of our stock by five-percent shareholders, or the issuance or exercise of rights to acquire our stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount of taxable income we generate in future periods.

Periodic examinations of our tax returns by the Internal Revenue Service ("IRS") or other taxing authorities could result in the payment of additional taxes. The IRS has completed audits of our tax returns for all tax years ended on or before December 31, 2007. All disputed issues with respect to these audits have been resolved, and all related tax assessments (including interest) have been paid. Our tax returns for years ended after December 31, 2007 and Vanguard's tax returns for fiscal years after June 30, 2004 are subject to examination by the IRS.

SOURCES AND USES OF CASH

Our liquidity for the year ended December 31, 2013 was primarily derived from net cash provided by operating activities, cash on hand and borrowings under our revolving credit facility. We had approximately $113 million of cash and cash equivalents on hand at December 31, 2013 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $406 million based on our borrowing base calculation as of December 31, 2013.

Our primary source of operating cash is the collection of accounts receivable. As such, our operating cash flow is negatively impacted by lower levels of cash collections and higher levels of bad debt due to unfavorable shifts in payer mix, growth in admissions of uninsured and underinsured patients, and other factors.

Net cash provided by operating activities was $589 million in the year ended December 31, 2013 compared to $593 million in the year ended December 31, 2012. Key negative and positive factors contributing to the change between the 2013 and 2012 periods include the following:

- Increased income from continuing operations before income taxes of $139 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, litigation and investigation costs, impairment and restructuring charges, acquisition-related costs, and depreciation and amortization in the year ended December 31, 2013 compared to the year ended December 31, 2012;
- The unfavorable impact of increased DSH receivables of $30 million primarily related to the Texas uncompensated care 1115 waiver program;
- $20 million less cash used in operating activities from discontinued operations;
- An increase of $51 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;
- $50 million of additional interest payments primarily due to $37 million of interest payments related to the Vanguard debt refinanced in connection with the acquisition on October 1, 2013; and
- Income tax payments of $6 million in the year ended December 31, 2013 compared to $13 million in the year ended December 31, 2012.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash. These initiatives may include the sale of excess land, buildings or other underutilized or inefficient assets.

Capital expenditures were $691 million and $508 million in the years ended December 31, 2013 and 2012, respectively.

In October 2012, we announced that our board of directors had authorized the repurchase of up to $500 million of our common stock through a share repurchase program that expired in December 2013. Under the program, shares could be purchased in the open market or through privately negotiated transactions in a manner consistent with applicable securities laws and regulations, including pursuant to a Rule 10b5-1 plan we maintained. Shares were repurchased at times and in amounts based on market conditions and other factors. Pursuant to the share repurchase program, we paid approximately $100 million to repurchase a total of 3,406,324 shares during the period from the commencement of the program through December 31, 2012, and we paid approximately $400 million to repurchase a total of 9,484,974 shares during the period from January 1, 2013 to December 31, 2013.

We record our investments that are available-for-sale at fair market value. As shown in Note 13 to the Condensed Consolidated Financial Statements, the majority of our investments are valued based on quoted market prices or other observable inputs. We have no investments that we expect will be negatively affected by the current economic downturn that will materially impact our financial condition, results of operations or cash flows.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

We have a senior secured revolving credit facility (as amended, the "Credit Agreement"), that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016, subject to our repayment or refinancing on or before November 3, 2014 of approximately $238 million of the aggregate outstanding principal amount of our 9 1/4% senior notes due 2015 (approximately $474 million of which was outstanding at December 31, 2013). If such repayment or refinancing does not occur, borrowings under the Credit Agreement will be due November 3, 2014. We are in compliance with all covenants and conditions in our Credit Agreement. There were $405 million of cash borrowings outstanding under the revolving credit facility at December 30, 2013, and we had approximately $189 million of standby letters of credit outstanding. Our borrowing availability under the Credit Agreement was $406 million based on our borrowing base calculation as of December 31, 2013.

In October 2013, we sold $2.8 billion aggregate principal amount of 8 1/8% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8 1/8% senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard. In addition, in accordance with the terms of the Credit Agreement, on October 15, 2013, we increased the maximum aggregate principal amount of our revolving credit facility from $800 million to $1 billion, subject to borrowing availability.

In May 2013, we sold $1.050 billion aggregate principal amount of 4 3/8% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4 3/8% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, commencing on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately $767 million aggregate principal amount outstanding of our 8 7/8% senior secured notes due 2019 in a tender offer and to call approximately $158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold $850 million aggregate principal amount of 4 ½% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4½% 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.

Table of Contents

For additional information regarding our long-term debt, see Note 6 to the accompanying Consolidated Financial Statements.

LIQUIDITY

From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time. We believe our existing debt agreements, the significant recent changes to which are described above, provide significant flexibility for future secured or unsecured borrowings.

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest and income tax payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that has caused, and in the future could cause, us to use our senior secured revolving credit facility as a source of liquidity. We believe that existing cash and cash equivalents on hand, availability under our revolving credit facility, anticipated future cash provided by operating activities, and our investments in marketable securities of our captive insurance companies classified as noncurrent investments on our balance sheet should be adequate to meet our current cash needs. These sources of liquidity should also be adequate to finance planned capital expenditures, payments on the current portion of our long-term debt and other presently known operating needs.

Long-term liquidity for debt service will be dependent on improved cash provided by operating activities and, given favorable market conditions, future borrowings or refinancings. However, our cash requirements could be materially affected by the use of cash in acquisitions of businesses and repurchases of securities, and also by a deterioration in our results of operations, as well as the various uncertainties discussed in this and other sections of this report, which could require us to pursue any number of financing options, including, but not limited to, additional borrowings, debt refinancings, asset sales or other financing alternatives. The level, if any, of these financing sources cannot be assured.

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our period-end balance sheets. We do not have any significant European sovereign debt exposure.

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are volume growth, including the acquisition of outpatient businesses, physician recruitment and alignment strategies, expansion of our services businesses within Conifer, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, underperforming hospitals, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management peers because of geographic and other differences in hospital portfolios.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the years ended December 31, 2013, 2012 and 2011 include $392 million, $953 million and $908 million, respectively, of net operating revenues and $72 million, $132 million and $115 million, respectively, of operating income generated from general hospitals operated by us under operating lease arrangements (one hospital as of December 31, 2013 and four hospitals of December 31, 2012 and 2011). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet. The one remaining operating lease is currently scheduled to expire in 2027. If we are unable to extend this lease or purchase the hospital, we would no longer generate revenues or expenses from the hospital.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $315 million of standby letters of credit outstanding and guarantees as of December 31, 2013.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 21 to our Consolidated Financial Statements included in this report for a discussion of recently issued accounting standards.

Table of Contents

CRITICAL ACCOUNTING ESTIMATES

In preparing our Consolidated Financial Statements in conformity with GAAP, we must use estimates and assumptions that affect the amounts reported in our Consolidated Financial Statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable, given the particular circumstances in which we operate. Actual results may vary from those estimates.

We consider our critical accounting estimates to be those that (1) involve significant judgments and uncertainties, (2) require estimates that are more difficult for management to determine, and (3) may produce materially different outcomes under different conditions or when using different assumptions.

Our critical accounting estimates cover the following areas:

- Recognition of net operating revenues, including contractual allowances and provision for doubtful accounts;
- Electronic health record incentives;
- Accruals for general and professional liability risks;
- Accruals for defined benefit plans;
- Impairment of long-lived assets;
- Impairment of goodwill, and
- Accounting for income taxes.

REVENUE RECOGNITION

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, and managed care and other health plans, as well as certain uninsured patients under the Compact.

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs, which were more prevalent in earlier periods, and certain other payments, such as DSH, DGME, IME and bad debt expense, which are based on our hospitals' cost reports, are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded by us could change by material amounts.

We have a system and estimation process for recording Medicare net patient revenue and estimated cost report settlements. This results in us recording accruals to reflect the expected final settlements on our cost reports. For filed cost reports, we record the accrual based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports, and a corresponding valuation allowance is recorded as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of December 31, 2013, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $13 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in

reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

Revenues related to self-pay patients may qualify for a discount under the Compact, whereby the gross charges based on established billing rates would be reduced by an estimated discount for contractual allowance.

We believe that adequate provision has been made for any adjustments that may result from final determination of amounts earned under all the above arrangements. We know of no material claims, disputes or unsettled matters with any payers that would affect our revenues for which we have not adequately provided for in our Consolidated Financial Statements.

Although outcomes vary, our policy is to attempt to collect amounts due from patients, including co-pays and deductibles due from patients with insurance, at the time of service while complying with all federal and state laws and regulations, including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Generally, as required by EMTALA, patients may not be denied emergency treatment due to inability to pay. Therefore, services, including the legally required medical screening examination and stabilization of the patient, are performed without delaying to obtain insurance information. In non-emergency circumstances or for elective procedures and services, it is our policy to verify insurance prior to a patient being treated; however, there are various exceptions that can occur. Such exceptions can include, for example, instances where (1) we are unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid or Victims of Crime, and it takes several days or weeks before qualification for such benefits is confirmed or denied, and (3) under physician orders we provide services to patients that require immediate treatment.

We provide for an allowance against accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer over a look-back period, and other relevant factors. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance as of December 31, 2012, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonable likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the volume of patients through our emergency departments, the increased burden of co-pays and deductibles to be made by patients with insurance, and business practices related to collection efforts. These factors continuously change and can have an impact on collection trends and our estimation process.

Our practice is to reduce the net carrying value of self-pay accounts receivable, including accounts related to the co-pays and deductibles due from patients with insurance, to their estimated net realizable value at the time of billing. Generally, uncollected balances are assigned to Conifer between 90 to 180 days, once patient responsibility has been identified. When accounts are assigned to Conifer by the hospital, the accounts are completely written off the hospital's books through the provision for doubtful accounts, and an estimated future recovery amount is calculated and recorded as a receivable on the hospital's books at the same time. The estimated future recovery amount is adjusted based on the aging of the accounts and changes to actual recovery rates. The estimated future recovery amount for self-pay accounts is written down whereby it is fully reserved if the amount is not paid within two years after the account is assigned to Conifer. At the present time, our new acquisitions have not been fully integrated into our Conifer collections processes.

Managed care accounts are collected through the regional business offices of Conifer, whereby the account balances remain in the related hospital's patient accounting system and on the hospital's books, and are adjusted based on an analysis of the net realizable value as they age. Generally, managed care accounts collected by Conifer are gradually written down whereby they are fully reserved if the accounts are not paid within two years.

Changes in the collectability of aged managed care accounts receivable are ongoing and impact our provision for doubtful accounts. We continue to experience payment pressure from managed care companies concerning amounts of past billings. We aggressively pursue collection of these accounts receivable using all means at our disposal, including arbitration and litigation, but we may not be successful.

ELECTRONIC HEALTH RECORD INCENTIVES

Under certain provisions of ARRA, federal incentive payments are available to hospitals, physicians and certain other professionals when they adopt, implement or upgrade ("AIU") certified EHR technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety and effectiveness of care. Providers can become eligible for annual Medicare incentive payments by demonstrating meaningful use of EHR technology in each period over four periods. Medicaid providers can receive their initial incentive payment by satisfying AIU criteria, but must demonstrate meaningful use of EHR technology in subsequent years in order to qualify for additional payments. Hospitals may be eligible for both Medicare and Medicaid EHR incentive payments; however, physicians and other professionals may be eligible for either Medicare or Medicaid incentive payments, but not both. Hospitals that are meaningful users under the Medicare EHR incentive payment program are deemed meaningful users under the Medicaid EHR incentive payment program and do not need to meet additional criteria imposed by a state. Medicaid EHR incentive payments to providers are 100% federally funded and administered by the states. CMS established calendar year 2011 as the first year states could offer EHR incentive payments. Before a state may offer EHR incentive payments, the state must submit and CMS must approve the state's incentive plan.

We recognize Medicaid EHR incentive payments in our consolidated statements of operations for the first payment year when: (1) CMS approves a state's EHR incentive plan; and (2) our hospital or employed physician acquires certified EHR technology (i.e., when AIU criteria are met). Medicaid EHR incentive payments for subsequent payment years are recognized in the period during which the specified meaningful use criteria are met. We recognize Medicare EHR incentive payments when: (1) the specified meaningful use criteria are met; and (2) contingencies in estimating the amount of the incentive payments to be received are resolved.

The meaningful use information submitted to CMS is subject to review, verification and audit. Additionally, the final Medicare and Medicaid EHR incentive payments under ARRA are based on financial and statistical data, which may be estimated using historical trends and current factors, in the settled Medicare cost report for the cost reporting period that begins in the federal fiscal year in which the criteria are met. We have acquired, developed and implemented systems to accumulate the information necessary to demonstrate meaningful use of EHR technology. We also have a system and estimation process for recording the financial and statistical data utilized as part of the cost reporting process. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. Cost report settlements are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded by us could change by material amounts. Final settlement of cost reports, which could impact the financial and statistical data on which EHR incentives are based, or a determination that meaningful use was not attained could result in adjustment to previously recognized EHR incentive payments or retrospective recoupment of incentive payments.

ACCRUALS FOR GENERAL AND PROFESSIONAL LIABILITY RISKS

We accrue for estimated professional and general liability claims, to the extent not covered by insurance, when they are probable and can be reasonably estimated. We maintain reserves, which are based on actuarial estimates for the portion of our professional liability risks, including incurred but not reported claims, to the extent we do not have insurance coverage. Our liability consists of estimates established based upon discounted actuarial calculations using several factors, including the number of expected claims, estimates of losses for these claims based on recent and historical settlement amounts, estimates of incurred but not reported claims based on historical experience, the timing of historical payments, and risk free discount rates used to determine the present value of projected payments. We consider the number of expected claims, average cost per claim and discount rate to be the most significant assumptions in estimating accruals for general and professional liabilities. Our liabilities are adjusted for new claims information in the period such information becomes known. Malpractice expense is recorded within other operating expenses in the accompanying Consolidated Statements of Operations.

Our estimated reserves for professional and general liability claims will change significantly if future claims differ from expected trends. We believe it is reasonably likely for there to be a 5% increase or decrease in the number of expected claims or average cost per claim. Based on our reserves and other information as of December 31, 2013, a 5% increase in the number of

expected claims would increase the estimated reserves by $37 million, and a 5% decrease in the number of expected claims would decrease the estimated reserves by $33 million. A 5% increase in the average cost per claim would increase the estimated reserves by $52 million, and a 5% decrease in the average cost per claim would decrease the estimated reserves by $46 million. Because our estimated reserves for future claim payments are discounted to present value, a change in our discount rate assumption could also have a significant impact on our estimated reserves. Our discount rate was 2.45%, 1.18% and 1.35% at December 31, 2013, 2012 and 2011, respectively. A 100 basis point increase or decrease in the discount rate would change the estimated reserves by $17 million. In addition, because of the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes, our ultimate liability for professional and general liability claims could change materially from our current estimates.

The table below shows the case reserves and incurred but not reported and loss development reserves as of December 31, 2013, 2012 and 2011:

	December 31,		
	2013	2012	2011
Case reserves	$ 175	$ 97	$ 111
Incurred but not reported and loss development reserves	575	272	319
Total undiscounted reserves	**$ 750**	**$ 369**	**$ 430**

Several actuarial methods, including the incurred, paid loss development and Bornhuetter-Ferguson methods, are applied to our historical loss data to produce estimates of ultimate expected losses and the resulting incurred but not reported and loss development reserves. These methods use our specific historical claims data related to paid losses and loss adjustment expenses, historical and current case reserves, reported and closed claim counts, and a variety of hospital census information. Based on these analyses, we determine our estimate of the professional liability claims, including the incurred but not reported and loss development reserve estimates. The determination of our estimates involves subjective judgment and could result in material changes to our estimates in future periods if our actual experience is materially different than our assumptions.

Malpractice claims generally take 4 to 5 years to settle from the time of the initial reporting of the occurrence to the settlement payment. Accordingly, the percentage of undiscounted reserves as of both December 31, 2013 and 2012 representing unsettled claims is approximately 99%.

The following table, which includes both our continuing and discontinued operations, presents the amount of our accruals for professional and general liability claims and the corresponding activity therein:

	Years Ended December 31,		
	2013	2012	2011
Accrual for professional and general liability claims, beginning of the year	$ 356	$ 412	$ 467
Assumed from acquisition	361	0	0
Expense (income) related to:(1)			
Current year	102	86	107
Prior years	13	(2)	10
Expense (income) from discounting	(13)	4	22
Total incurred loss and loss expense	102	88	139
Paid claims and expenses related to:			
Current year	(3)	(2)	(2)
Prior years	(117)	(142)	(192)
Total paid claims and expenses	(120)	(144)	(194)
Accrual for professional and general liability claims, end of year	**$ 699**	**$ 356**	**$ 412**

(1) Total malpractice expense for continuing operations, including premiums for insured coverage, was $112 million, $92 million and $108 million in the years ended December 31, 2013, 2012 and 2011, respectively.

ACCRUALS FOR DEFINED BENEFIT PLANS

Our defined benefit plan obligations and related costs are calculated using actuarial concepts. The discount rate is a critical assumption in determining the elements of expense and liability measurement. We evaluate this critical assumption

annually. Other assumptions include employee demographic factors such as retirement patterns, mortality, turnover and rate of compensation increase.

The discount rate enables us to state expected future cash payments for benefits as a present value on the measurement date. The guideline for setting these rates is a high-quality long-term corporate bond rate. A lower discount rate increases the present value of benefit obligations and increases pension expense. Our discount rates for 2013 ranged from 5.00% to 5.18% and our discount rate for 2012 was 4.00%. The assumed discount rate for pension plans reflects the market rates for high-quality corporate bonds currently available. A 100 basis point decrease in the assumed discount rate would increase total net periodic pension expense for 2013 by approximately $7 million and would increase the projected benefit obligation at December 31, 2013 by approximately $157 million. A 100 basis point increase in the assumed discount rate would decrease net periodic pension expense for 2014 by approximately $5 million and decrease the projected benefit obligation at December 31, 2013 by approximately $131 million.

IMPAIRMENT OF LONG-LIVED ASSETS

We evaluate our long-lived assets for possible impairment annually or whenever events or changes in circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future undiscounted cash flows. If the estimated future undiscounted cash flows are less than the carrying value of the assets, we calculate the amount of an impairment charge if the carrying value of the long-lived assets exceeds the fair value of the assets. The fair value of the assets is estimated based on appraisals, established market values of comparable assets or internal estimates of future net cash flows expected to result from the use and ultimate disposition of the asset. The estimates of these future cash flows are based on assumptions and projections we believe to be reasonable and supportable. They require our subjective judgments and take into account assumptions about revenue and expense growth rates. These assumptions may vary by type of facility and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

We report long-lived assets to be disposed of at the lower of their carrying amounts or fair values less costs to sell. In such circumstances, our estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows.

Fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the following risks:

- future financial results of our hospitals, which can be impacted by volumes of insured patients and declines in commercial managed care patients, terms of managed care payer arrangements, our ability to collect accounts due from uninsured and managed care payers, loss of volumes as a result of competition, and our ability to manage costs such as labor costs, which can be adversely impacted by union activity and the shortage of experienced nurses;

- changes in payments from governmental health care programs and in government regulations such as reductions to Medicare and Medicaid payment rates resulting from government legislation or rule-making or from budgetary challenges of states in which we operate;

- how the hospitals are operated in the future; and

- the nature of the ultimate disposition of the assets.

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and other long-lived assets, primarily capitalized software costs classified in other intangible assets, of one of our hospitals to their estimated fair values, primarily due to a decline in the fair value of real estate in the market in which the hospital operates and a decline in the estimated fair value of equipment. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospital indicated the carrying value of the hospital's long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospital's long-lived assets and compared the fair value estimate to the carrying value of the

Table of Contents

hospital's long-lived assets. Because the fair value estimate was lower than the carrying value of the hospital's long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of this hospital improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, this hospital is at risk of future impairments, particularly if we spend significant amounts of capital at the hospital without generating a corresponding increase in the hospital's fair value or if the fair value of the hospital's real estate or equipment continues to decline. The aggregate carrying value of assets held and used of the hospital for which an impairment charge was recorded was $44 million as of December 31, 2013 after recording the impairment charge. We also recorded $16 million of restructuring costs, $14 million of employee severance costs, $2 million of lease termination costs, and $59 million in acquisition-related costs. Additionally, in our most recent impairment analysis as of December 31, 2013, we had two hospitals with an aggregate carrying value of long-lived assets of approximately $227 million whose estimated future undiscounted cash flows exceeded the carrying value of long-lived assets by an aggregate amount of approximately $150 million. These two hospitals had the smallest excess of future undiscounted cash flows on an annual basis necessary to recover the carrying value of their assets. We also had one hospital whose estimated future undiscounted cash flows did not exceed the carrying value of long-lived assets. However, the fair value of those assets, based on an independent appraisal, exceeded the carrying value by $23 million, so no impairment was recorded. Future adverse trends that result in necessary changes in the assumptions underlying these estimates of future undiscounted cash flows could result in the hospitals' estimated cash flows being less than the carrying value of the assets, which would require a fair value assessment of the long-lived assets and, if the fair value amount is less than the carrying value of the assets, impairment charges would occur and could be material.

IMPAIRMENT OF GOODWILL

Goodwill represents the excess of costs over the fair value of assets of businesses acquired. Goodwill and other intangible assets acquired in purchase business combinations and determined to have indefinite useful lives are not amortized, but instead are subject to impairment tests performed at least annually. For goodwill, we perform the test at the reporting unit level, as defined by applicable accounting standards, when events occur that require an evaluation to be performed or at least annually. If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. Estimates of fair value are based on appraisals, established market prices for comparable assets or internal estimates of future net cash flows and presume stable, improving or, in some cases, declining results at our hospitals, depending on their circumstances. If the presumed level of performance does not occur as expected, impairment may result.

As of December 31, 2013, our continuing operations consisted of two operating segments, our Conifer subsidiary and our hospital and other operations. In the three months ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard, and we moved our hospitals in Philadelphia, Pennsylvania from our Southern States region into our Northeast region. Our hospital and other operations segment was structured as follows as of December 31, 2013:

- Our California region included all of our hospitals and other operations in California;
- Our Central region included all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the San Antonio or South Texas markets;
- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern States region included all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;
- Our Detroit market region included all of our hospitals and other operations in the Detroit, Michigan area;
- Our Phoenix market included all of our hospitals and other operations in the Phoenix, Arizona area;
- Our San Antonio market included all of our hospitals and other operations in the San Antonio, Texas area; and

Table of Contents

- Our South Texas market included all of our hospitals and other operations in the Brownsville, Texas and Harlingen, Texas areas.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

The goodwill balance related to our acquisition of Vanguard has not yet been allocated by reporting unit. Our allocated goodwill balance is primarily related to our Southern States region, which totals approximately $388 million, and our Central region, which totals approximately $370 million. In our latest impairment analysis as of December 31, 2013, the estimated fair value of these regions exceeded the carrying value of long-lived assets, including goodwill, by approximately 18% and 116%, respectively.

ACCOUNTING FOR INCOME TAXES

We account for income taxes using the asset and liability method. This approach requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of temporary differences between the carrying amounts and the tax bases of assets and liabilities. Income tax receivables and liabilities and deferred tax assets and liabilities are recognized based on the amounts that more likely than not will be sustained upon ultimate settlement with taxing authorities.

Developing our provision for income taxes and analysis of uncertain tax positions items requires significant judgment and knowledge of federal and state income tax laws, regulations and strategies, including the determination of deferred tax assets and liabilities and, if necessary, any valuation allowances that may be required for deferred tax assets.

We assess the realization of our deferred tax assets to determine whether an income tax valuation allowance is required. Based on all available evidence, both positive and negative, and the weight of that evidence to the extent such evidence can be objectively verified, we determine whether it is more likely than not that all or a portion of the deferred tax assets will be realized. The main factors that we consider include:

- Cumulative profits/losses in recent years, adjusted for certain nonrecurring items;
- Income/losses expected in future years;
- Unsettled circumstances that, if unfavorably resolved, would adversely affect future operations and profit levels;
- The availability, or lack thereof, of taxable income in prior carryback periods that would limit realization of tax benefits; and
- The carryforward period associated with the deferred tax assets and liabilities.

During the year ended December 31, 2011, we reduced our valuation allowance by $5 million based on 2011 profits and projected profits for 2012. During the year ended December 31, 2012, we reduced the valuation allowance by an additional $5 million based on 2012 profits and projected profits for 2013. During the year ended December 31, 2013, the valuation allowance increased by $51 million, $28 million due to the acquisition of Vanguard and $23 million primarily due to the recording of deferred tax assets for state net operating loss carryforwards that have a full valuation allowance. The remaining $107 million balance in the valuation allowance as of December 31, 2013 is primarily attributable to certain state net operating loss carryovers that, more likely than not, will expire unutilized.

We consider many factors when evaluating our uncertain tax positions, and such judgments are subject to periodic review. Tax benefits associated with uncertain tax positions are recognized in the period in which one of the following conditions is satisfied: (1) the more likely than not recognition threshold is satisfied; (2) the position is ultimately settled through negotiation or litigation; or (3) the statute of limitations for the taxing authority to examine and challenge the position has expired. Tax benefits associated with an uncertain tax position are derecognized in the period in which the more likely than not recognition threshold is no longer satisfied.

While we believe we have adequately provided for our income tax receivables or liabilities and our deferred tax assets or liabilities, adverse determinations by taxing authorities or changes in tax laws and regulations could have a material adverse effect on our consolidated financial position, results of operations or cash flows.

Table of Contents

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments as of December 31, 2013. The fair values were determined based on quoted market prices for the same or similar instruments. The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2014	2015	2016	2017	2018	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 149	$ 539	$ 25	$ 49	$ 1,047	$ 8,653	$ 10,462	$ 10,833
Average effective interest rates	7.0%	8.9%	5.3%	8.7%	6.6%	7.0%	7.0%	
Variable rate long-term debt	$ —	$ —	$ 405	$ —	$ —	$ —	$ 405	$ 405
Average effective interest rates	—	—	2.38%	—	—	—	2.38%	

At December 31, 2013, the potential reduction of annual pretax earnings due to a one percentage point (100 basis point) increase in variable interest rates on long-term debt would be approximately $4 million.

At December 31, 2013, we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as “special-purpose” or “variable-interest” entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements by us. Thus, we have no exposure to the financing, liquidity, market or credit risks associated with such entities.

We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage or prepayment features.

Table of Contents

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

To Our Shareholders:

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934, as amended. Management assessed the effectiveness of Tenet's internal control over financial reporting as of December 31, 2013. This assessment was performed under the supervision of and with the participation of management, including the chief executive officer and chief financial officer.

In making this assessment, management used criteria based on the framework in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on the assessment using the COSO framework, management concluded that Tenet's internal control over financial reporting was effective as of December 31, 2013.

As more fully described under the heading "Basis of Presentation" in Note 1 to the Consolidated Financial Statements in Item 8, we acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013. We excluded Vanguard from our 2013 assessment of the effectiveness of our internal control over financial reporting. Vanguard accounted for approximately 12% and 39% of net and total assets, respectively, and 13% of net operating revenues of our consolidated financial statement amounts as of and for the year ended December 31, 2013. We expect that our internal control system will be fully implemented at Vanguard during 2014 and correspondingly evaluated by us for effectiveness.

Tenet's internal control over financial reporting as of December 31, 2013 has been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as stated in their report, which is included herein. Deloitte & Touche LLP has also audited Tenet's Consolidated Financial Statements as of and for the year ended December 31, 2013, and that firm's audit report on such Consolidated Financial Statements is also included herein.

Internal control over financial reporting cannot provide absolute assurance of achieving financial reporting objectives because of its inherent limitations. Internal control over financial reporting is a process that involves human diligence and compliance and is subject to lapses in judgment and breakdowns resulting from human failures. Internal control over financial reporting also can be circumvented by collusion or improper management override. Because of such limitations, there is a risk that material misstatements may not be prevented or detected on a timely basis by internal control over financial reporting. However, these inherent limitations are known features of the financial reporting process. Therefore, it is possible to design into the process safeguards to reduce, though not eliminate, this risk.

/s/ TREVOR FETTER	/s/ DANIEL J. CANCELMI
Trevor Fetter	Daniel J. Cancelmi
President and Chief Executive Officer	*Chief Financial Officer*
February 24, 2014	February 24, 2014

Table of Contents

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the internal control over financial reporting of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2013, based on criteria established in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. As described in Management's Report on Internal Control Over Financial Reporting, management excluded from its assessment the internal control over financial reporting at Vanguard Health Systems, Inc., which was acquired on October 1, 2013 and whose financial statements constitute 12% and 39% of net and total assets, respectively, and 13% of net operating revenues of the consolidated financial statement amounts as of and for the year ended December 31, 2013. Accordingly, our audit did not include the internal control over financial reporting at Vanguard Health Systems, Inc. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on the criteria established in *Internal Control — Integrated Framework (1992)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 20 13 of the Company and our report dated February 24, 2014 expressed an unqualified opinion on those financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 24, 2014

Table of Contents

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
Tenet Healthcare Corporation
Dallas, Texas

We have audited the accompanying consolidated balance sheets of Tenet Healthcare Corporation and subsidiaries (the "Company") as of December 31, 2013 and 2012, and the related consolidated statements of operations, other comprehensive income (loss), changes in equity, and cash flows for each of the three years in the period ended December 31, 2013. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements and financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Tenet Healthcare Corporation and subsidiaries at December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2013, based on the criteria established in *Internal Control* — Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 24, 2014 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Dallas, Texas
February 24, 2014

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

Period	Total Number of Shares Purchased (In Thousands)	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program (In Thousands)	Maximum Dollar Value of Shares That May Yet Be Purchased Under the Program (In Millions)
November 1, 2012 through December 31, 2012	**3,406**	**$ 29.36**	**3,406**	**$ 400**
January 1, 2013 through January 31, 2013	531	37.13	531	380
February 1, 2013 through February 28, 2013	914	39.30	914	344
March 1, 2013 through March 31, 2013	1,010	43.95	1,010	300
Three Months Ended March 31, 2013	**2,455**	**40.74**	**2,455**	**300**
May 1, 2013 through May 31, 2013	933	46.78	933	256
June 1, 2013 through June 30, 2013	1,065	45.71	1,065	208
Three Months Ended June 30, 2013	**1,998**	**46.21**	**1,998**	**208**
July 1, 2013 through July 31, 2013	166	46.08	166	200
August 1, 2013 through August 31, 2013	1,045	40.43	1,045	158
September 1, 2013 through September 30, 2013	1,431	40.35	1,431	100
Three Months Ended September 30, 2013	**2,642**	**40.75**	**2,642**	**100**
November 1, 2103 through November 30, 2013	796	42.28	796	66
December 1, 2013 through December 31, 2013	1,594	41.62	1,594	0
Three Months Ended December 31, 2013	**2,390**	**41.84**	**2,390**	**0**
Total	**12,891**	**$ 38.79**	**12,891**	**$ 0**

Repurchased shares are recorded based on settlement date and are held as treasury stock.

Mandatory Convertible Preferred Stock

In April 2012, we repurchased and subsequently retired 298,700 shares of our 7% mandatory convertible preferred stock with a carrying value of $289 million. In a related private financing, we issued an additional $141 million aggregate principal amount of our 6 1/4% senior secured notes due 2018 at a premium for $142 million of cash proceeds and an additional $150 million aggregate principal amount of our 8% senior notes due 2020. We recorded the difference between the carrying value and the amount paid to redeem the preferred stock in April 2012 as preferred stock dividends in the accompanying Consolidated Statements of Operations. On October 1, 2012, the remaining 46,300 shares outstanding of our mandatory convertible preferred stock automatically converted to 1,978,633 shares of our common stock. We accrued approximately $6 million, or $17.50 per share, for dividends on the preferred stock in the three months ended March 31, 2012 and $1 million in each of the three months ended June 30, 2012 and September 30, 2012, and paid the dividends in April, July and October 2012, respectively.

Table of Contents

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.

Table of Contents

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.

Table of Contents

Should we dispose of additional hospitals or other assets in the future, we may incur additional asset impairment and restructuring charges in future periods.

NOTE 5. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

We recognized impairment charges on long-lived assets in 2013, 2012 and 2011 because the fair values of those assets or groups of assets indicated that the carrying amount was not recoverable. The fair value estimates were derived from appraisals, established market values of comparable assets, or internal estimates of future net cash flows. These fair value estimates can change by material amounts in subsequent periods. Many factors and assumptions can impact the estimates, including the future financial results of the hospitals, how the hospitals are operated in the future, changes in health care industry trends and regulations, and the nature of the ultimate disposition of the assets. In certain cases, these fair value estimates assume the highest and best use of hospital assets in the future to a market place participant is other than as a hospital. In these cases, the estimates are based on the fair value of the real property and equipment if utilized other than as a hospital. The impairment recognized does not include the costs of closing the hospitals or other future operating costs, which could be substantial. Accordingly, the ultimate net cash realized from the hospitals, should we choose to sell them, could be significantly less than their impaired value.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospital's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

As of December 31, 2013, our continuing operations consisted of two operating segments, our hospital and other operations and our Conifer subsidiary. In the three months ended December 31, 2013, we acquired 28 hospitals (plus one more under construction), 39 outpatient centers and five health plans, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas, through our acquisition of Vanguard, and we moved our hospitals in Philadelphia, Pennsylvania from our Southern States region into our Northeast region. Our hospital and other operations segment was structured as follows as of December 31, 2013:

- Our California region included all of our hospitals and other operations in California;
- Our Central region included all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the San Antonio or South Texas markets;
- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern States region included all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;
- Our Detroit market region included all of our hospitals and other operations in the Detroit, Michigan area;
- Our Phoenix market included all of our hospitals and other operations in the Phoenix, Arizona area;
- Our San Antonio market included all of our hospitals and other operations in the San Antonio, Texas area; and
- Our South Texas market included all of our hospitals and other operations in the Brownsville, Texas and Harlingen, Texas areas.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our statement of operations as they are incurred. Our restructuring plans focus on various aspects of operations, including aligning our operations in the most strategic and cost-effective structure. Certain restructuring and acquisition-related costs are based upon estimates. Changes in estimates are recognized as they occur.

Year Ended December 31, 2013

During the year ended December 31, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $103 million. This amount included a $12 million impairment charge for the write-down of buildings and equipment and

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**

Table of Contents

Credit Agreement

We have a senior secured revolving credit facility (as amended, "Credit Agreement"), that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016, subject to our repayment or refinancing on or before November 3, 2014 of approximately $238 million of the aggregate outstanding principal amount of our 9 1/4% senior notes due 2015 (approximately $474 million of which was outstanding at December 31, 2013). If such repayment or refinancing does not occur, borrowings under the Credit Agreement will be due November 3, 2014. The revolving credit facility is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. In addition, borrowings under the Credit Agreement are guaranteed by our wholly owned hospital subsidiaries. Outstanding revolving loans accrued interest during a six-month initial period that ended in May 2012 at the rate of either (i) a base rate plus a margin of 1.25% or (ii) the London Interbank Offered Rate ("LIBOR") plus a margin of 2.25% per annum. Outstanding revolving loans now accrue interest at a base rate plus a margin ranging from 1.00% to 1.50% or LIBOR plus a margin ranging from 2.00% to 2.50% per annum based on available credit. An unused commitment fee was payable on the undrawn portion of the revolving loans at a six-month initial rate that ended in May 2012 of 0.438% per annum. The unused commitment fee now ranges from 0.375% to 0.500% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At December 31, 2013, we had $405 million of cash borrowings outstanding under the revolving credit facility subject to an interest rate of 2.38%, and we had approximately $189 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $406 million was available for borrowing under the revolving credit facility at December 31, 2013.

Senior Notes and Senior Secured Notes

In October 2013, we sold $2.8 billion aggregate principal amount of 8 1/8% senior notes, which will mature on April 1, 2022, and $1.8 billion aggregate principal amount of 6% senior secured notes, which will mature on October 1, 2020. We will pay interest on the 8 1/8% senior notes and 6% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, commencing on April 1, 2014. The proceeds from the sale of the notes were used to finance the acquisition of Vanguard.

In May 2013, we sold $1.050 billion aggregate principal amount of 4 3/8% senior secured notes, which will mature on October 1, 2021. We will pay interest on the 4 3/8% senior secured notes semi-annually in arrears on January 1 and July 1 of each year, commencing on January 1, 2014. We used a portion of the proceeds from the sale of the notes to purchase approximately $767 million aggregate principal amount outstanding of our 8 7/8% senior secured notes due 2019 in a tender offer and to call approximately $158 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $171 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs.

In February 2013, we sold $850 million aggregate principal amount of 4 1/2% senior secured notes, which will mature on April 1, 2021. We will pay interest on the 4 1/2% senior secured notes semi-annually in arrears on April 1 and October 1 of each year, which payments commenced on October 1, 2013. We used a portion of the proceeds from the sale of the notes to purchase approximately $645 million aggregate principal amount outstanding of our 10% senior secured notes due 2018 in a tender offer and to call approximately $69 million of the remaining aggregate principal amount outstanding of those notes. In connection with the purchase, we recorded a loss from early extinguishment of debt of $177 million, primarily related to the difference between the purchase prices and the par values of the purchased notes, as well as the write-off of unamortized note discounts and issuance costs. The remaining net proceeds were used for general corporate purposes, including the repayment of borrowings under our senior secured revolving credit facility.

Table of Contents

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:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Long-term debt, including capital lease obligations	$ 10,867	$ 149	$ 539	$ 430	$ 49	$ 1,047	$ 8,653
Long-term non-cancelable operating leases	$ 663	$ 137	$ 117	$ 102	$ 80	$ 56	$ 171

Rental expense under operating leases, including short-term leases, was $186 million, $156 million and $143 million in the years ended December 31, 2013, 2012 and 2011, respectively. Included in rental expense for each of these periods was sublease income of $8 million, which were recorded as a reduction to rental expense.

NOTE 7. GUARANTEES

Consistent with our policy on physician relocation and recruitment, we provide income guarantee agreements to certain physicians who agree to relocate to fill a community need in the service area of one of our hospitals and commit to remain in practice in the area for a specified period of time. Under such agreements, we are required to make payments to the physicians in excess of the amounts they earn in their practices up to the amount of the income guarantee. The income guarantee periods are typically 12 months. If a physician does not fulfill his or her commitment period to the community, which is typically three years subsequent to the guarantee period, we seek recovery of the income guarantee payments from the physician on a prorated basis. We also provide revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals with terms generally ranging from one to three years.

At December 31, 2013, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $108 million. We had a liability of $78 million recorded for these guarantees included in other current liabilities at December 31, 2013.

We have also guaranteed minimum rent revenue to certain landlords who built medical office buildings on or near our hospital campuses. The maximum potential amount of future payments under these guarantees at December 31, 2013 was $16 million. We had a liability of $2 million recorded for these guarantees at December 31, 2013, of which $1 million was included in other current liabilities and $1 million was included in other long-term liabilities.

Table of Contents

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.

Table of Contents

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

Table of Contents

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

Table of Contents

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:

Table of Contents

	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.

Table of Contents

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	$ —	$ —

Table of Contents

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**

Table of Contents

	2013	2012
Conifer		
As of January 1:		
Goodwill	$ 78	$ 0
Accumulated impairment losses	0	0
Total	78	0
Goodwill acquired during the year and purchase price allocation adjustments	5	78
Total	**$ 83**	**$ 78**
As of December 31:		
Goodwill	$ 83	$ 78
Accumulated impairment losses	0	0
Total	**$ 83**	**$ 78**

The following table provides information regarding other intangible assets, which are included in the accompanying Consolidated Balance Sheets as of December 31, 2013 and 2012:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2013:			
Capitalized software costs	$ 1,260	$ (475)	$ 785
Long-term debt issuance costs	230	(31)	199
Trade Names	81	0	81
Contracts	64	(2)	62
Other	80	(15)	65
Total	**$ 1,715**	**$ (523)**	**$ 1,192**
As of December 31, 2012:			
Capitalized software costs	$ 927	$ (399)	$ 528
Long-term debt issuance costs	106	(25)	81
Other	43	(2)	41
Total	**$ 1,076**	**$ (426)**	**$ 650**

Estimated future amortization of intangibles with finite useful lives as of December 31, 2013 is as follows:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Amortization of intangible assets	$ 1,102	$ 224	$ 206	$ 126	$ 82	$ 77	$ 387

NOTE 12. INVESTMENTS AND OTHER ASSETS

The principal components of investments and other assets in our accompanying Consolidated Balance Sheets are as follows:

	December 31,	
	2013	2012
Marketable debt securities	$ 62	$ 15
Equity investments in unconsolidated health care entities(1)	56	22
Total investments	118	37
Cash surrender value of life insurance policies	25	21
Long-term deposits	35	16
Land held for expansion, long-term receivables and other assets	227	88
Investments and other assets	**$ 405**	**$ 162**

(1) Equity earnings of unconsolidated affiliates are included in net operating revenues in the accompanying Consolidated Statements of Operations and were $15 million and $8 million in of the years ended December 31, 2013 and 2012, respectively.

Our policy is to classify investments that may be needed for cash requirements as “available-for-sale.” In doing so, the carrying values of the shares and debt instruments are adjusted at the end of each accounting period to their market values through a credit or charge to other comprehensive income (loss), net of taxes. At both December 31, 2013 and 2012, there were less than $1 million of accumulated unrealized gains on these investments.

NOTE 13. ACCUMULATED OTHER COMPREHENSIVE LOSS

Our accumulated other comprehensive loss is comprised of the following:

Table of Contents

	December 31, 2013	December 31, 2012
Unamortized realized losses from interest rate lock derivatives	$ —	$ (1)
Adjustments for defined benefit plans	(24)	(67)
Accumulated other comprehensive loss	**$ (24)**	**$ (68)**

There was a tax effect allocated to the adjustments for our defined benefit plans for the years ended December 31, 2013 and 2012 of $(25) million and $9 million, respectively.

NOTE 14. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Insurance

At December 31, 2013 and 2012, the aggregate current and long-term professional and general liability reserves in our accompanying Consolidated Balance Sheets were approximately $699 million and $356 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.45%, 1.18% and 1.35% at December 31, 2013, 2012 and 2011, respectively.

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period.

Included in other operating expenses, net, in the accompanying Consolidated Statements of Operations is malpractice expense of $112 million, $92 million and $108 million for the years ended December 31, 2013, 2012 and 2011, respectively.

NOTE 15. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

Governmental Reviews

Health care companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. Certain of our individual facilities have received inquiries from government agencies, and our facilities may receive such inquiries in future periods. The following material governmental reviews, which have been previously reported, are currently pending.

- *Kyphoplasty*—From March 2009 through July 2010, seven of our hospitals became the subject of a review by the U.S. Department of Justice ("DOJ") and certain other federal agencies regarding the appropriateness of inpatient treatment for Medicare patients receiving kyphoplasty, which is a surgical procedure used to treat certain spinal conditions. We believe this review is part of a national investigation and is related to a qui tam settlement between the government and the manufacturer and distributor of Kyphon, the product used in performing kyphoplasty procedures. In January 2013, we paid $900,000 to settle potential Medicare reimbursement claims against one of our hospitals subject to this review. Management has established a reserve, as described below, to reflect the current

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.

Table of Contents

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**

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

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.

Table of Contents

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

We completed our acquisition of Vanguard effective October 1, 2013. The facilities acquired as part of the Vanguard acquisition utilize different information technology systems than our other facilities. We have excluded all of the Vanguard operations from our assessment of and conclusion on the effectiveness of our internal control over financial reporting. The rules of the Securities and Exchange Commission ("SEC") require us to include acquired entities in our assessment of the effectiveness of internal control over financial reporting no later than the annual management report following the first anniversary of the acquisition. We will complete the evaluation and integration of the Vanguard operations within the required timeframe and report management's assessment of our internal control over financial reporting, including the acquired hospitals and other operations, in our first annual report in which such assessment is required. Other than the Vanguard acquisition, there were no changes in our internal control over financial reporting during the quarter ended December 31, 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report with respect to our operations that existed prior to the Vanguard acquisition. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Exchange Act and the SEC rules thereunder.

Management's report on internal control over financial reporting is set forth on page 88 and is incorporated herein by reference. The independent registered public accounting firm that audited the financial statements included in this report has issued an attestation report on our internal control over financial reporting as set forth on page 89 herein.

ITEM 9B. OTHER INFORMATION

None.

Table of Contents

PART III.

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Certain information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K. Information concerning our *Standards to Conduct*, by which all of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide appears under Item I, Business — Compliance and Ethics, of Part I of this report.

ITEM 11. EXECUTIVE COMPENSATION

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Information required by this Item is hereby incorporated by reference to our definitive proxy statement in accordance with General Instruction G(3) to Form 10-K.

Table of Contents

PART IV.

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

FINANCIAL STATEMENTS

The Consolidated Financial Statements and notes thereto can be found on pages 91 through 129.

FINANCIAL STATEMENT SCHEDULES

Schedule II—Valuation and Qualifying Accounts (included on page 140).

All other schedules and financial statements of the Registrant are omitted because they are not applicable or not required or because the required information is included in the Consolidated Financial Statements or notes thereto.

EXHIBITS

(2) Plan of Acquisition, Reorganization, Arrangement, Liquidation or Succession

(a) Agreement and Plan of Merger, dated as of June 24, 2013, by and among the Registrant, Orange Merger Sub, Inc. and Vanguard Health Systems, Inc. (Incorporated by reference to Exhibit 2.1 to Registrant's Current Report on Form 8-K, dated and filed June 24, 2013)

(3) Articles of Incorporation and Bylaws

(a) Amended and Restated Articles of Incorporation of the Registrant, as amended and restated May 8, 2008 (Incorporated by reference to Exhibit 3(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, filed August 5, 2008)

(b) Certificate of Designation, Preferences, and Rights of Series A Junior Participating Preferred Stock, par value $0.15 per share, dated January 7, 2011 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(c) Certificate of Change Pursuant to NRS 78.209, filed with the Nevada Secretary of State effective October 10, 2012 (Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K, dated October 10, 2012 and filed October 11, 2012)

(d) Amended and Restated Bylaws of the Registrant, as amended and restated effective January 7, 2011 (Incorporated by reference to Exhibit 3.2 to Registrant's Current Report on Form 8-K, dated and filed January 7, 2011)

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(b) Third Supplemental Indenture, dated as of November 6, 2001, between the Registrant and The Bank of New York, as trustee, relating to 6 7/8% Senior Notes due 2031 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated November 6, 2001 and filed November 9, 2001)

(c) Seventh Supplemental Indenture, dated as of June 18, 2004, between the Registrant and The Bank of New York, as trustee, relating to 9 7/8% Senior Notes due 2014 (Incorporated by reference to Exhibit 4(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2004, filed August 3, 2004)

(d) Eighth Supplemental Indenture, dated as of January 28, 2005, between the Registrant and The Bank of New York, as trustee, relating to 9¼% Senior Notes due 2015 (Incorporated by reference to Exhibit 4(g) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2004, filed March 8, 2005)

(e) Twelfth Supplemental Indenture, dated as of August 17, 2010, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 8% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed August 17, 2010)

(f) Fourteenth Supplemental Indenture, dated as of November 21, 2011, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 6¼% Senior Secured Notes due 2018 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated November 21, 2011 and filed November 22, 2011)

(g) Fifteenth Supplemental Indenture, dated as of October 16, 2012, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating to 4¾% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(h) Sixteenth Supplemental Indenture, dated as of October 16, 2012, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 6¾% Senior Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 16, 2012)

(i) Seventeenth Supplemental Indenture, dated as of February 5, 2013, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating 4½% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed February 5, 2013)

(j) Twentieth Supplemental Indenture, dated as of May 30, 2013, by and among the Registrant, The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, and the guarantors party thereto, relating 4 3/8% Senior Secured Notes due 2021 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated May 30, 2013 and filed May 31, 2013)

(k) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(l) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 6% Senior Secured Notes due 2020 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(m) Indenture, dated as of September 27, 2013, among THC Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8 1/8% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.3 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(n) Supplemental Indenture, dated as of October 1, 2013, among the Registrant, certain of its subsidiaries and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to 8 1/8% Senior Notes due 2022 (Incorporated by reference to Exhibit 4.4 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(10) Material Contracts

(a) Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated October 19, 2010 and filed October 20, 2010)

(b) Amendment No. 1, dated as of November 29, 2011, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc.,

as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated November 29, 2011 and filed December 1, 2011)

(c) Amendment No. 2, dated as of January 23, 2014, to that certain Amended and Restated Credit Agreement, dated as of October 19, 2010, among the Registrant, the lenders and issuers party thereto, Citicorp USA, Inc., as administrative agent, Bank of America, N.A., as syndication agent, Citigroup Global Markets Inc. and Banc of America Securities LLC, as joint lead arrangers, and the joint bookrunners and co-documentation agents named therein†

(d) Stock Pledge Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated March 3, 2009 and filed March 5, 2009)

(e) Second Amendment to Stock Pledge Agreement, dated as of June 15, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated June 15, 2009 and filed June 16, 2009)

(f) Collateral Trust Agreement, dated as of March 3, 2009, by and among the Registrant, as pledgor, The Bank of New York Mellon Trust Company, N.A., as collateral trustee, and the other pledgors party thereto (Incorporated by reference to Exhibit 10.2 to Registrant's Current Report on Form 8-K, dated March 3, 2009 and filed March 5, 2009)

(g) Exchange and Registration Rights Agreement, dated as of October 1, 2013, by and among the Registrant, certain of its subsidiaries, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Barclays Capital Inc., Citigroup Global Markets Inc. and Wells Fargo Securities, LLC (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated and filed October 1, 2013)

(h) Letter from the Registrant to Trevor Fetter, dated November 7, 2002 (Incorporated by reference to Exhibit 10(k) to Registrant's Transition Report on Form 10-K for the seven-month transition period ended December 31, 2002, filed May 15, 2003)*

(i) Letter from the Registrant to Trevor Fetter dated September 15, 2003 (Incorporated by reference to Exhibit 10(l) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, filed November 10, 2003)*

(j) Letter from the Registrant to Keith B. Pitts dated June 21, 2013 *†

(k) Letter from the Registrant to Britt T. Reynolds, dated December 15, 2011 (Incorporated by reference to Exhibit 10(j) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2011, filed February 28, 2012)*

(l) Letter from the Registrant to Daniel J. Cancelmi, dated September 6, 2012 (Incorporated by reference to Exhibit 10(c) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012) *

(m) Letter from the Registrant to Audrey Andrews, accepted January 24, 2013 (Incorporated by reference to Exhibit 10(m) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2012, filed February 26, 2013)*

(n) Letter from the Registrant to Cathy Fraser, dated August 29, 2006 (Incorporated by reference to Exhibit 10(k) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2007, filed February 26, 2008)*

Table of Contents

(o) Letter from the Registrant to R. Scott Ramsey, dated September 10, 2012 (Incorporated by reference to Exhibit 10(d) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(p) Tenet Second Amended and Restated Executive Severance Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(e) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(q) Board of Directors Retirement Plan, effective January 1, 1985, as amended August 18, 1993, April 25, 1994 and July 30, 1997 (Incorporated by reference to Exhibit 10(q) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2003, filed November 10, 2003)*

(r) Tenet Healthcare Corporation Seventh Amended and Restated Supplemental Executive Retirement Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(f) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(s) Ninth Amended and Restated Tenet 2001 Deferred Compensation Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(g) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(t) Second Amended and Restated Tenet 2006 Deferred Compensation Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(h) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(u) Tenet Healthcare Corporation Second Amended and Restated 1994 Directors Stock Option Plan (Incorporated by reference to Exhibit 10(u) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(v) First Amended and Restated 1991 Stock Incentive Plan (Incorporated by reference to Exhibit 10(v) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(w) Second Amended and Restated 1995 Stock Incentive Plan (Incorporated by reference to Exhibit 10(w) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(x) Second Amended and Restated Tenet Healthcare Corporation 1999 Broad-Based Stock Incentive Plan (Incorporated by reference to Exhibit 10(x) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2006, filed February 27, 2007)*

(y) Fifth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(i) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(z) Form of Stock Award used to evidence grants of stock options and/or restricted units under the Fourth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan (Incorporated by reference to Exhibit 10.3 to Registrant's Current Report on Form 8-K, dated February 14, 2006 and filed February 17, 2006)*

(aa) Third Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(j) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(bb) Forms of Award used to evidence (i) initial grants of restricted stock units to directors, (ii) annual grants of restricted stock units to directors, (iii) grants of stock options to executives, and (iv) grants of restricted stock units to executives, all under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Exhibit 10(aa) to Registrant's Annual Report on Form 10-K for the year ended December 31, 2008, filed February 24, 2009)*

(cc) Award Agreement, dated June 13, 2013, used to evidence grant of performance-based restricted stock units to Trevor Fetter under the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by

reference to Exhibit 10 to Registrant's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, filed August 6, 2013)*

(dd) Form of Award used to evidence grants of performance cash awards under the Fourth Amended and Restated Tenet Healthcare Corporation 2001 Stock Incentive Plan and the Amended and Restated Tenet Healthcare 2008 Stock Incentive Plan (Incorporated by reference to Registrant's Annual Report on Form 10-K for the year ended December 31, 2009, filed February 23, 2010)*

(ee) Tenet Special RSU Deferral Plan (Incorporated by reference to Exhibit 10(d) to Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009, filed May 5, 2009)*

(ff) Second Amended Tenet Healthcare Corporation Annual Incentive Plan, as amended and restated effective December 31, 2008 (Incorporated by reference to Exhibit 10(k) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, filed November 7, 2012)*

(gg) Form of Indemnification Agreement entered into with each of the Registrant's directors (Incorporated by reference to Exhibit 10(a) to Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005, filed November 1, 2005)

(21) Subsidiaries of the Registrant†

(23) Consent of Deloitte & Touche LLP†

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Trevor Fetter, President and Chief Executive Officer†

(b) Certification of Daniel J. Cancelmi, Chief Financial Officer†

(32) Section 1350 Certifications of Trevor Fetter, President and Chief Executive Officer, and Daniel J. Cancelmi, Chief Financial Officer†

(101 INS) XBRL Instance Document

(101 SCH) XBRL Taxonomy Extension Schema Document

(101 CAL) XBRL Taxonomy Extension Calculation Linkbase Document

(101 DEF) XBRL Taxonomy Extension Definition Linkbase Document

(101 LAB) XBRL Taxonomy Extension Label Linkbase Document

(101 PRE) XBRL Taxonomy Extension Presentation Linkbase Document

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* Management contract or compensatory plan or arrangement.
† Filed herewith.

Table of Contents

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: February 24, 2014 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Date: February 24, 2014 By: /s/ TREVOR FETTER
Trevor Fetter
President, Chief Executive Officer and Director
(Principal Executive Officer)

Date: February 24, 2014 By: /s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer
(Principal Financial Officer)

Date: February 24, 2014 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Date: February 24, 2014 By: /s/ JOHN ELLIS BUSH
John Ellis Bush
Director

Date: February 24, 2014 By: /s/ BRENDA J. GAINES
Brenda J. Gaines
Director

Date: February 24, 2014 By: /s/ KAREN M. GARRISON
Karen M. Garrison
Director

Date: February 24, 2014 By: /s/ EDWARD A. KANGAS
Edward A. Kangas
Director

Date: February 24, 2014 By: /s/ J. ROBERT KERREY
J. Robert Kerrey
Director

Date: February 24, 2014 By: /s/ RICHARD R. PETTINGILL
Richard R. Pettingill
Director

Table of Contents

Date: February 24, 2014	By:	/s/ RONALD A. RITTENMEYER
		Ronald A. Rittenmeyer
		Director
Date: February 24, 2014	By:	/s/ JAMES A. UNRUH
		James A. Unruh
		Director

Table of Contents

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(In Millions)

	Balance at Beginning of Period	Additions Charged To: Costs and Expenses(1)(2)	Additions Charged To: Other Accounts	Deductions(3)	Other Items(4)	Balance at End of Period
Allowance for doubtful accounts:						
Year ended December 31, 2013	$ 401	$ 975	$ —	$ (787)	$ —	$ 589
Year ended December 31, 2012	$ 397	$ 789	$ —	$ (785)	$ —	$ 401
Year ended December 31, 2011	$ 352	$ 721	$ —	$ (676)	$ —	$ 397
Valuation allowance for deferred tax assets						
Year ended December 31, 2013	$ 56	$ 23	$ (1)	$ —	$ 29	$ 107
Year ended December 31, 2012	$ 61	$ (5)	$ —	$ —	$ —	$ 56
Year ended December 31, 2011	$ 66	$ (5)	$ —	$ —	$ —	$ 61

(1) Includes amounts recorded in discontinued operations.
(2) Before considering recoveries on accounts or notes previously written off.
(3) Accounts written off.
(4) Vanguard acquisition.

Exhibit 10(c)

AMENDMENT NO. 2

AMENDMENT NO. 2, dated as of January 23, 2014 (this "*Amendment*"), by and among Tenet Healthcare Corporation, a Nevada corporation (the "*Borrower*"), Citicorp USA, Inc., as Administrative Agent (in such capacity, the "*Administrative Agent*") under the Credit Agreement (as defined below) , the Loan Parties and the Lenders party hereto.

PRELIMINARY STATEMENTS:

WHEREAS, reference is hereby made to the Amended and Restated Credit Agreement, dated as of October 19, 2010 (as amended, supplemented, amended and restated or otherwise modified from time to time, the "*Credit Agreement*"), among the Borrower, the Administrative Agent and each Lender and Issuer from time to time party thereto (capitalized terms used but not defined herein having the meaning provided in the Credit Agreement);

WHEREAS, pursuant to Section 11.1 of the Credit Agreement, the Borrower has requested that the Administrative Agent and the Requisite Lenders consent to the amendment to the Credit Agreement set forth herein;

WHEREAS, each Lender party hereto has agreed to consent to the amendment set forth herein, in each case, on the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the premises and agreements, provisions and covenants herein contained, the parties hereto agree as follows:

1. **Amendment to the Credit Agreement**. Effective as of the Amendment Effective Date (as defined below) and subject to the satisfaction of the terms and conditions set forth herein, the definition of "Excluded Subsidiary" is hereby amended and restated in its entirety to read as follows:

"*Excluded Subsidiary*" means, (a) each Subsidiary of the Borrower designated from time to time by the Borrower as such, unless the Borrower shall have subsequently revoked such designation by written notice of such revocation to the Administrative Agent and such Subsidiary shall have complied with the requirements of *Section 7.10(a) (Additional Collateral and Guaranties)* ; *provided*, *however*, that (i) the aggregate total assets of all Excluded Subsidiaries on the last day of the most recent fiscal period for which financial statements have been delivered pursuant to *Section 6.1* (*Financial Statements*) shall be less than 30% of the Consolidated total assets of the Borrower and its Subsidiaries as of such date and (ii) the aggregate gross revenues of all such Subsidiaries for any Fiscal Quarter shall be less than 30% of the Consolidated gross revenues of the Borrower and its Subsidiaries for such Fiscal Quarter, in each case determined in accordance with GAAP, (b) any Subsidiary of the Borrower of which less than 60% of the outstanding Voting Stock is, at the time, directly or indirectly, owned or controlled by the Borrower or one or more Guarantors and (c) as of the Effective Date, each of the Subsidiaries of the Borrower listed on *Schedule 1.1(a)* ("*Excluded Subsidiaries*").

2. **Conditions to Effectiveness**. This Amendment shall become effective on the date when each of the following conditions precedent have first been satisfied (the "*Amendment Effective Date*"):

(a) this Amendment shall have been executed and delivered by the Borrower, the Loan Parties, the Requisite Lenders and the Administrative Agent;

(b) there shall have been paid to the Administrative Agent, for the account of itself and the Lenders, as applicable, all fees and expenses (including, to the extent invoiced, the reasonable fees and expenses of Weil, Gotshal & Manges LLP) due and payable on or before the Amendment Effective Date;

(c) each of the representations set forth in Section 3 hereof shall be true and correct as of the Amendment Effective Date; and

(d) no Default or Event of Default shall have occurred and be continuing as of the Amendment Effective Date.

3. **Representations and Warranties**. By its execution of this Amendment, the Borrower hereby certifies that:

(a) (i) each Loan Party has taken all necessary action to authorize the execution, delivery and performance of this Amendment, (ii) this Amendment has been duly executed and delivered by each Loan Party, (iii) this Amendment is the legal, valid and binding obligation of the each Loan Party, enforceable against it in accordance with its terms, except as enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by general equitable principles and (iv) such execution, delivery and performance will not (A) contravene or violate any Loan Party's Constituent Documents, (B) violate any other Requirement of Law applicable to any Loan Party or any order or decree of any Governmental Authority or arbitrator applicable to the Borrower or (C) conflict with or result in the breach of, or constitute a default under, or result in or permit the termination or acceleration of, any Related Document or any other material Contractual Obligation of any Loan Party;

(b) each of the representations and warranties made by any Loan Party in the Credit Agreement, as amended hereby, and the other Loan Documents to which it respectively is a party or by which it is bound, is true and correct in all material respects on and as of the Amendment Effective Date (other than representations and warranties in any such Loan Document which expressly speak as of a specific date, which shall have been true and correct in all material respects as of such specific date); and

(c) no Default or Event of Default has occurred and is continuing.

4. **Acknowledgments; Liens Unimpaired**. Each Loan Party hereby acknowledges that it has read this Amendment and consents to the terms hereof, and further hereby affirms, confirms, represents, warrants and agrees that (a) notwithstanding the effectiveness of this Amendment, the obligations of such Loan Party under each of the Loan Documents to which it is a party shall not be impaired and each of the Loan Documents to which such Loan Party is a party is, and shall continue to be, in full force and effect and is hereby confirmed and ratified in all respects; (b) after giving effect to this Amendment, (i) the execution, delivery, performance or effectiveness of this Amendment shall not impair the validity, effectiveness or priority of the Liens granted pursuant to the Loan Documents and such Liens shall continue unimpaired with the same priority to secure repayment of all Obligations, whether heretofore or hereafter incurred and (ii) in the case of any Guarantor, its Guaranty, as and to the extent provided in the Loan Documents, shall

continue in full force and effect in respect of the Obligations under the Credit Agreement and the other Loan Documents; (c) the execution, delivery, performance or effectiveness of this Amendment does not require that any new filings be made or other action taken to perfect or maintain the perfection of such Liens; and (d) the position of the Lenders with respect to such Liens, the Collateral (as defined in the applicable Loan Documents) in which a security interest was granted pursuant to the Loan Documents, and the ability of the Collateral Agent to realize upon such Liens pursuant to the terms of the Loan Documents have not been adversely affected in any material respect by the execution, delivery, performance or effectiveness of this Amendment.

5. **Amendment, Modification and Waiver**. This Amendment may not be amended, modified or waived except in accordance with Section 11.1 of the Credit Agreement.

6. **Entire Agreement**. This Amendment, the Credit Agreement and the other Loan Documents constitute the entire agreement among the parties hereto with respect to the subject matter hereof and thereof and supersede all other prior agreements and understandings, both written and verbal, among the parties hereto with respect to the subject matter hereof. Except as expressly set forth herein, this Amendment shall not by implication or otherwise limit, impair, constitute a waiver of, or otherwise affect the rights and remedies of any party under, the Credit Agreement or other Loan Documents, nor alter, modify, amend or in any way affect any of the terms, conditions, obligations, covenants or agreements contained in the Credit Agreement or other Loan Documents, all of which are ratified and affirmed in all respects and shall continue in full force and effect. It is understood and agreed that each reference in each Loan Document to the Credit Agreement, whether direct or indirect, shall hereafter be deemed to be a reference to the Credit Agreement as amended hereby and that this Amendment is a Loan Document.

7. **GOVERNING LAW AND SUBMISSION TO JURISDICTION. SECTIONS 11.11 AND 11.12 OF THE CREDIT AGREEMENT ARE HEREBY INCORPORATED BY REFERENCE INTO THIS AMENDMENT AND SHALL APPLY HERETO MUTATIS MUTANDIS.**

8. **Waiver of Jury Trial**. Section 11.13 of the Credit Agreement is hereby incorporated by reference into this Amendment and shall apply hereto *mutatis mutandis*.

9. **Counterparts**. Section 11.16 of the Credit Agreement is hereby incorporated by reference into this Amendment and shall apply hereto *mutatis mutandis*.

10. **Entire Agreement**. Section 11.17 of the Credit Agreement is hereby incorporated by reference into this Amendment and shall apply hereto *mutatis mutandis*.

[SIGNATURE PAGES FOLLOW]

IN WITNESS WHEREOF, each of the undersigned has caused its duly authorized officer to execute and deliver this Amendment as of the date first written above.

CITICORP USA, INC.
as the Administrative Agent

By: /s/ Justin McMahan
Name: Justin McMahan
Title: Vice President

TENET HEALTHCARE CORPORATION,
as the Borrower

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

AMISUB (SFH), INC.
AMISUB OF NORTH CAROLINA, INC.
AMISUB OF SOUTH CAROLINA, INC.
BROOKWOOD HEALTH SERVICES, INC.
COASTAL CAROLINA MEDICAL CENTER, INC.
DELRAY MEDICAL CENTER, INC.
DOCTORS HOSPITAL OF MANTECA, INC.
DOCTORS MEDICAL CENTER OF MODESTO, INC.
EAST COOPER COMMUNITY HOSPITAL, INC.
FOUNTAIN VALLEY REGIONAL HOSPITAL AND MEDICAL CENTER
FRYE REGIONAL MEDICAL CENTER, INC.
HOUSTON SPECIALTY HOSPITAL, INC.
JFK MEMORIAL HOSPITAL, INC.
LAKEWOOD REGIONAL MEDICAL CENTER, INC.
LIFEMARK HOSPITALS OF FLORIDA, INC.
LOS ALAMITOS MEDICAL CENTER, INC.
NORTH FULTON MEDICAL CENTER, INC.
PALM BEACH GARDENS COMMUNITY HOSPITAL, INC.
PLACENTIA-LINDA HOSPITAL, INC.
SIERRA VISTA HOSPITAL, INC.
TENET GOOD SAMARITAN, INC.
TENET HEALTHSYSTEM BARTLETT, INC.
TENET HEALTHSYSTEM DESERT, INC.
TENET HEALTHSYSTEM DI, INC.
TENET HEALTHSYSTEM GB, INC.
TENET HEALTHSYSTEM HOSPITALS, INC.
TENET HEALTHSYSTEM NORTH SHORE, INC.
TENET HEALTHSYSTEM SGH, INC.
TENET HEALTHSYSTEM SL, INC.

[SIGNATURE PAGE TO AMENDMENT]

TENET HEALTHSYSTEM SPALDING, INC.
TENET HIALEAH HEALTHSYSTEM, INC.
TENET ST. MARY'S, INC.
TWIN CITIES COMMUNITY HOSPITAL, INC.
WEST BOCA MEDICAL CENTER, INC.

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

CGH HOSPITAL, LTD.
By: Coral Gables Hospital, Inc., as General Partner
HILTON HEAD HEALTH SYSTEM, L.P.
By: Tenet Physician Services — Hilton Head, Inc., as General Partner
NEW MEDICAL HORIZONS II, LTD.
By: Cypress Fairbanks Medical Center Inc., as General Partner
TENET FRISCO, LTD.
By: Tenet Healthsystem Hospitals, Inc., as General Partner
TENET HEALTHSYSTEM HAHNEMANN, L.L.C.
By: Tenet HealthSystem Philadelphia, Inc., as Sole Member
TENET HEALTHSYSTEM ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN, L.L.C.
By: Tenet HealthSystem Philadelphia, Inc., as Sole Member
TENET HOSPITALS LIMITED
By: Tenet Texas, Inc., as General Partner
TH HEALTHCARE, LTD.
By: Lifemark Hospitals, Inc., as General Partner

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

VHS SAN ANTONIO PARTNERS, LLC

By: VHS Acquisition Subsidiary Number 5, Inc., its Managing Member, and VHS Holding Company, Inc.

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

HOSPITAL DEVELOPMENT OF WEST PHOENIX, INC.
VHS ACQUISITION CORPORATION
VHS ACQUISITION SUBSIDIARY NUMBER 1, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 7, INC.
VHS ACQUISITION SUBSIDIARY NUMBER 9, INC.

[SIGNATURE PAGE TO AMENDMENT]

VHS CHILDREN'S HOSPITAL OF MICHIGAN, INC.
VHS DETROIT RECEIVING HOSPITAL, INC.
VHS HARPER-HUTZEL HOSPITAL, INC.
VHS HURON VALLEY-SINAI HOSPITAL, INC.
VHS OF ARROWHEAD, INC.
VHS OF ILLINOIS, INC.
VHS REHABILITATION INSTITUTE OF MICHIGAN, INC.
VHS SINAI-GRACE HOSPITAL, INC.
VHS WEST SUBURBAN MEDICAL CENTER, INC.
VHS WESTLAKE HOSPITAL, INC.
VHS OF PHOENIX, INC.

By: /s/ Tyler C. Murphy
Name: Tyler C. Murphy
Title: Treasurer

CITIBANK, N.A.,
as a Lender

By: /s/ Justin McMahan
Name: Justin McMahan
Title: Vice President

WELLS FARGO CAPITAL FINANCE LLC,
as a Lender

By: /s/ David Klages
Name: David Klages
Title: Duly Authorized Signor

Siemens Financial Services, Inc.,
as a Lender

By: /s/ John Finore
Name: John Finore
Title: Vice President

By: /s/ Uri Sky
Name: Uri Sky
Title: Vice President

[SIGNATURE PAGE TO AMENDMENT]

CIT HEALTHCARE LLC,
as a Lender

By: /s/ Barbara Perich
Name: Barbara Perich
Title: Director

Goldman Sachs Bank USA,
as a Lender

By: /s/ Michelle Latzoni
Name: Michelle Latzoni
Title: Authorized Signatory

ROYAL BANK OF CANADA,
as a Lender

By: /s/ Mustafa Topiwalla
Name: Mustafa Topiwalla
Title: Authorized Signatory

Bank of America, N.A.
as a Lender

By: /s/ Laura Weiland
Name: Laura Weiland
Title: Vice President

COMPASS BANK,
as a Lender

By: /s/ Marla Cannon
Name: Marla Cannon
Title: Vice President

[SIGNATURE PAGE TO AMENDMENT]

Exhibit 10(j)

[TENET LETTERHEAD]

June 21, 2013

Mr. Keith B. Pitts
Vice Chairman
Vanguard Health Systems, Inc.

Dear Keith:

I am pleased to offer you supplemental compensation and benefits in consideration of your transition to Tenet Healthcare Corporation in connection with Tenet's acquisition of Vanguard Health Systems, Inc. ("Acquisition"). By accepting these terms, you agree to waive any occurrence of "good reason" under your employment agreement with Vanguard that results from Vanguard no longer being a publicly-traded company as a result of the Acquisition or your acceptance of your role described herein. Except as modified below, other terms of your employment agreement will remain in effect. The terms included in this letter are contingent on the successful closing of the Acquisition and become effective at that time.

1. Role: Vice Chairman of Tenet, reporting to Tenet's President and Chief Executive Officer. Your position will be located at Tenet's headquarters in Dallas after a reasonable transition period from Nashville to be mutually agreed upon. (See Addendum for additional detail.)

2. Compensation and Benefits: You will be entitled to compensation and benefits as follows:

   a. Base Compensation: Your base compensation will continue to be an annual exempt rate of $700,000.00, payable bi-weekly.

   b. Benefits: You are eligible to receive all standard employee benefits in accordance with Tenet plans.

   c. Annual Incentive Plan: Your position is eligible to participate in Tenet's Annual Incentive Plan (AIP) according to the terms of the Plan. Your target award will continue to be 100% of your base salary. Participating in the AIP does not guarantee that an award will be made.

   d. Manager's Paid Time Off Plan: You are eligible to participate in the company's paid time off plan (the "MTO Plan") according to your tenure with the company (4 weeks per year).

   e. Long Term Incentives. As Vice Chairman, you will be eligible for future long-term incentive grants, which are typically awarded annually and based on guidelines established by Tenet's Compensation Committee. In your role, the current guideline for such an award has an annual value of between $2,000,000 and $2,500,000. In addition, you will receive an up-front grant of restricted stock units ("RSUs") valued at $2,500,000, which will be granted upon closing of the Acquisition. The RSUs will vest in the same manner as standard annual Tenet RSU grants, over three years in one-third annual increments.

3. Relocation: Tenet will provide relocation benefits related to your move to Dallas in accordance with its relocation policies for key executives. The details of these benefits will be provided in a separate communication.

4. Supplemental Executive Retirement Plan: You will be eligible to participate in Tenet's supplemental executive retirement plan (SERP), which provides enhanced retirement, disability and life insurance benefits, effective as of the close of the Acquisition. Upon completion of five years of service with Tenet following the closing of the Acquisition, the SERP will credit your pre-closing service with Vanguard for purposes of calculating SERP benefits. Details of that plan (e.g., benefit accrual levels, vesting terms) will be provided in a separate communication. Should Tenet's Compensation Committee determine to freeze or terminate the SERP plan following the Acquisition, you will be provided with a substitute of similar value.

5. Executive Severance Plan: At the time specified in the next paragraph, you will be eligible to participate in the Executive Severance Plan, which provides you with certain severance benefits in the event of a Qualifying Termination (i.e., Not for Cause or Good Reason) as defined in the plan. These benefits include severance benefits of two and one-half years of base salary and target annual bonus for a Qualifying Termination, and three years base salary and target annual bonus for Qualifying Termination related to a Change of Control.

   Participation will require execution of a Tenet Executive Severance Plan Agreement. Upon execution of this agreement, which must be completed within one year of the closing of the Acquisition, both parties agree to terminate your existing employment agreement with Vanguard.

   You will receive a separate communication containing more details about the plan, your participation in the plan and an agreement which you will need to sign, from the Executive Compensation Department following your employment date with Tenet.

6. Use of Company Aircraft: You will have priority access to private aircraft for business travel in accordance with Tenet's policies.

All payments to you are subject to applicable tax withholding, and nothing in this letter constitutes a contract to employ you for any specified time. This letter may be modified only by a writing signed by both you and a designated senior officer of Tenet.

If you accept these supplemental items and benefits, please sign and date this letter and return it to me. We are very excited about the Acquisition and look forward to you joining our team.

Sincerely,

/s/ Trevor Fetter

Trevor Fetter
President and CEO

cc: Cathy Fraser, SVP Human Resources
Paul Slavin, VP Executive and Corporate HR Services

Acknowledged and accepted:

/s/ Keith B. Pitts Date: 6/24, 2013
Signature

Addendum

Responsibilities of Vice-Chairman:

A. Primary responsibilities:

1. Responsible for sourcing, evaluating, and executing material mergers, acquisitions, divestitures, investments, joint ventures and similar corporate development activities across Tenet's business lines

2. Management responsibility for Tenet's current acquisitions and development department

3. Member of Tenet's Senior Operating Committee (top corporate officers)

4. Advisor on strategies to Tenet's CEO

5. Member of the board of managers (equivalent to board of directors) of Conifer

6. Represent Tenet as a director of the Federation of American Hospitals and other national-level industry or business organizations

7. Participate in all Tenet board meetings

8. Co-Chair of Tenet's Capital Expenditure Review Committee ("CERC")(1)

B. Extensive involvement in the following areas, in coordination with functional leaders:

1. Investor relations (i.e., represent Tenet at selected investor conferences or road shows, in coordination with CFO and SVP of IR)

2. Government relations (in coordination with SVP Public Affairs)

3. Industry relations (i.e., represent Tenet at industry conferences, C-level industry meetings, or other venues, in coordination with SVP Public Affairs)

(1) This management committee approves key investments/expenditures greater than $5 million.

Exhibit 21

Tenet Subsidiaries List
(As of 12/31/13)

All of the subsidiaries listed below are 100% owned by **Tenet Healthcare Corporation** unless otherwise indicated.

Conifer Holdings, Inc.

(a) Conifer Ethics and Compliance, Inc.
(a) Conifer Health Solutions, LLC — *ownership — Conifer Holdings, Inc., managing member (98%); Catholic Health Initiatives (2%)*
  (b) Conifer Patient Communications, LLC
  (b) Conifer Revenue Cycle Solutions, LLC
    (c) Conifer HIM & Revenue Integrity Services, LLC
    (c) Syndicated Office Systems, LLC
    (c) Hospital RCM Services, LLC
    (c) United Patient Financing, Inc.
  (b) Conifer Value-Based Care, LLC
    (c) InforMed Medical Management Services, LLC
    (c) InforMed Insurance Services, LLC

DigitalMed, Inc.

National Imaging Center Holdings, Inc.

(a) DMC Imaging, L.L.C.

National Surgery Center Holdings, Inc.

(a) Bluffton Okatie Surgery Center, L.L.C.
(a) Coral Ridge Outpatient Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
(a) El Paso Day Surgery, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (61%); other outside members (39%)*
(a) GCSA Ambulatory Surgery Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
(a) Murdock Ambulatory Surgical Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
(a) NSCH/USP Desert Surgery Centers, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (50.1%); Surgical Health Partners, Inc. (49.9%)*
  (b) El Mirador Surgery Center, L.L.C. — *ownership — NSCH/USP Desert Surgery Centers, LLC, managing member (77.93%); other outside members (22.07%)*
(a) Pacific Endoscopy and Surgery Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (55%); other outside members (45%)*
(a) Pediatric Surgery Center - Odessa, LLC— *ownership — National Surgery Center Holdings, Inc., managing member (60%); other outside members (40%)*
(a) Pediatric Surgery Centers, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (60%); other outside members (40%)*
(a) South Florida Ambulatory Surgical Center, LLC — *ownership — National Surgery Center Holdings, Inc. (50.65%); other outside physician partners (49.35%)*
(a) Surgery Center of Okeechobee, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
(a) Surgery Center of Pembroke Pines, L.L.C. — *ownership — National Surgery Center Holdings, Inc., managing member (67.5%); other outside members (32.5%)*
(a) The Surgery Center at Jensen Beach, LLC— *ownership — National Surgery Center Holdings, Inc., managing member (53.5%); other outside members (46.5%)*
(a) Theda Oaks Gastroenterology & Endoscopy Center, LLC — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*
(a) Winter Haven Ambulatory Surgical Center, L.L.C. — *ownership — National Surgery Center Holdings, Inc., managing member (51%); other outside members (49%)*

National Urgent Care Holdings, Inc.
- (a) AMC/North Fulton Urgent Care #1, L.L.C.
- (a) AMC/North Fulton Urgent Care #2, L.L.C.
- (a) AMC/North Fulton Urgent Care #3, L.L.C.
- (a) AMC/North Fulton Urgent Care #4, L.L.C.
- (a) AMC/North Fulton Urgent Care #5, L.L.C.
- (a) AMC/North Fulton Urgent Care #6, L.L.C.
- (a) Camp Creek Urgent Care, L.L.C.
- (a) Des Peres Urgent Care, L.L.C.
- (a) Memphis Urgent Care #1, L.L.C.
- (a) Memphis Urgent Care #2, L.L.C.
- (a) NUCH of Georgia, L.L.C.
- (a) NUCH of Texas
- (a) Olive Branch Urgent Care #1, LLC
- (a) Selma Carlson, Inc.
- (a) St. Louis Urgent Care #2, L.L.C.
- (a) St. Louis Urgent Care #3, L.L.C.
- (a) Walker Street Imaging Care, Inc.
- (a) West Boynton Urgent Care, L.L.C.

NME Headquarters, Inc.

NME Properties Corp.
- (a) NME Properties, Inc.
  - (b) Lake Health Care Facilities, Inc.
- (a) NME Property Holding Co., Inc.
- (a) Tenet HealthSystem SNF-LA, Inc.

NME Psychiatric Hospitals, Inc.
- (a) The Huron Corporation

NME Rehabilitation Properties, Inc.
- (a) R.H.S.C. El Paso, Inc.

TenetCare, Inc.
- (a) National Diagnostic Imaging Centers, Inc.
- (a) TenetCare Frisco, Inc.
  - (b) Centennial ASC, L.P. *(1% GP: TenetCare Frisco, Inc.; 99% LP: Tenet Hospitals Limited)*
- (a) TenetCare Tennessee, Inc.

Tenet Healthcare Foundation

Tenet HealthSystem Holdings, Inc.
- (a) Tenet HealthSystem Medical, Inc.
  - (b) 601 N 30th Street III, Inc.
    - (c) 601 N 30th Street I, L.L.C. — *ownership — 601 N 30th Street III, Inc. (74.06%)*
      Tenet HealthSystem Medical, Inc. (25.94%)
      - (d) 601 N 30th Street II, L.L.C.
  - (b) American Medical (Central), Inc.
    - (c) Amisub (Heights), Inc.
    - (c) Amisub (Twelve Oaks), Inc.
    - (c) Lifemark Hospitals, Inc.
      - (d) Amisub of Texas, Inc.
      - (d) Houston Network, Inc.
      - (d) Houston Specialty Hospital, Inc.
      - (d) Lifemark Hospitals of Florida, Inc.
        - (e) Surgicare of Miramar, L.L.C. — *ownership — Lifemark Hospitals of Florida, Inc., managing member (50.97%); other outside members (49.03%)*

(d) Lifemark Hospitals of Louisiana, Inc.
(d) TH Healthcare, Ltd. — *ownership — GP: Lifemark Hospitals, Inc. (1%); LP: Amisub of Texas, Inc. (70.1%); LP: Amisub (Heights), Inc. (10.3%); LP: Amisub (Twelve Oaks), Inc. (18.6%)*
(e) Park Plaza Hospital Billing Center, L.L.C.
(c) Tenet Employment, Inc.
(b) AMI Diagnostic Services, Inc.
(b) AMI Information Systems Group, Inc.
(b) AMI/HTI Tarzana Encino Joint Venture — *ownership — Tenet HealthSystem Medical, Inc. (30%) Amisub of California, Inc. (26%); New H Acute, Inc. (12%) AMI Information Systems Group, Inc. (7%)*
(b) Amisub (Hilton Head), Inc.
(c) Hilton Head Health System, L.P. — *ownership — Amisub (Hilton Head), Inc. (79%) Tenet Physician Services - Hilton Head, Inc. (21%)*
(b) Amisub (North Ridge Hospital), Inc.
(c) NRMC Physician Services, L.L.C.
(b) Amisub (SFH), Inc.
(c) Saint Francis Hospital Billing Center, L.L.C.
(c) Saint Francis Surgery Center, L.L.C. *(60.6061% member interest)*
(c) Tenet HealthSystem SF-SNF, Inc.
(b) Amisub of California, Inc.
(b) Amisub of North Carolina, Inc.
(c) Central Carolina Ambulatory Surgery Center, LLC
(b) Amisub of South Carolina, Inc.
(c) Rock Hill Surgery Center, L.P. — *ownership — Amisub of South Carolina, Inc. (72%) Surgical Center of Rock Hill (28%)*
(c) Tenet Rehab Piedmont, Inc.
(b) Brookwood Center Development Corporation
(c) Alabama Digestive Health Endoscopy Center, L.L.C. *(53% member interest)*
(c) Brookwood Home Health, LLC — *ownership — Brookwood Center Development Corporation (51%); other outside member (49%)*
(c) BWP Associates, Ltd. — *ownership — Brookwood Center Development Corporation (80%) Brookwood Development, Inc. (20%)*
(c) C.K. of Birmingham, LLC
(c) Hoover Doctors Group, Inc.
(c) Medplex Outpatient Medical Centers, Inc.
(c) Medplex Outpatient Surgery Center, Ltd. — *ownership — Others (15%) Brookwood Center Development Corporation (8% GP, 73.765% LP); Hoover Doctors Group, Inc. (1% LP); Medplex Outpatient Medical Centers, Inc. (1% LP)*
(b) Brookwood Development, Inc.
(b) Brookwood Health Services, Inc.
(c) Brookwood Garages, L.L.C.
(b) Brookwood Parking Associates, Ltd. — *ownership — Tenet HealthSystem Medical, Inc. (99%), Brookwood Garages, L.L.C. (1%)*
(b) Coastal Carolina Medical Center, Inc.
(c) Coastal Carolina Pro Fee Billing, L.L.C.
(b) Coastal Carolina Physician Practices, L.L.C.
(c) Hardeeville Medical Group, L.L.C.
(c) Hardeeville Primary Care, L.L.C.
(b) Cumming Medical Ventures, Inc.
(b) East Cooper Community Hospital, Inc.
(c) The Southeastern Spine Institute Surgery Center, L.L.C. — *ownership — East Cooper Community Hospital, Inc., managing member (55%); other outside members (45%)*
(b) Eastern Professional Properties, Inc.
(b) Frye Regional Medical Center, Inc.
(c) FryeCare Outpatient Imaging, L.L.C.

- (c) Frye Heart Excellence Team, LLC *(50% member interest)*
- (c) Frye Home Infusion, Inc.
- (c) Guardian Health Service, L.L.C. *(50% member interest)*
- (c) Tate Surgery Center, L.L.C.
- (c) Unifour Neurosurgery, L.L.C.
- (c) Viewmont Surgery Center, L.L.C.

(b) Magnetic Resonance Imaging of San Luis Obispo, Inc.
(b) New H Acute, Inc.
(b) North Fulton Medical Center, Inc.

- (c) Endoscopy Consultants, LLC *— ownership — North Fulton Medical Center, Inc. (51%); other outside physician partners (49%)*
- (c) Georgia Center, LLC *— ownership — North Fulton Medical Center, Inc. (51%); other outside physician partners (49%)*
- (c) North Fulton GI Center, L.L.C.
- (c) Northwoods Surgery Center, LLC
- (c) NorthPoint Health System, Inc.
- (c) Northwoods Member, Inc.
- (c) Roswell Georgia Surgery Center, L.L.C.

(b) North Fulton MOB Ventures, Inc.
(b) Palm Beach Gardens Community Hospital, Inc.

- (c) Palm Beach Gardens Cardiac and Vascular Partners, LLC *— ownership — Palm Beach Gardens Community Hospital, Inc. (50%); other outside physician partners (50%)*

(b) Piedmont Urgent Care and Industrial Health Centers, Inc.

- (c) Catawba-Piedmont Cardiothoracic Surgery, L.L.C.
- (c) Imaging Center at Baxter Village, L.L.C.
- (c) Piedmont Behavioral Medicine Associates, LLC
- (c) Piedmont Cardiovascular Physicians, L.L.C.
- (c) Piedmont Carolina OB/GYN of York County, L.L.C.
- (c) Piedmont Carolina Vascular Surgery, L.L.C.
- (c) Piedmont East Urgent Care Center, L.L.C.
- (c) Piedmont Express Care at Sutton Road, L.L.C.
- (c) Piedmont Family Practice at Baxter Village, L.L.C.
- (c) Piedmont Family Practice at Rock Hill, L.L.C.
- (c) Piedmont Family Practice at Tega Cay, L.L.C.
- (c) Piedmont General Surgery Associates, L.L.C.
- (c) Piedmont Internal Medicine at Baxter Village, L.L.C.
- (c) Piedmont Internal Medicine and Family Practice at York, L.L.C.
- (c) Piedmont Pulmonology, L.L.C.
- (c) Piedmont Surgical Specialists, L.L.C.
- (c) Piedmont Urgent Care Center at Baxter Village, LLC
- (c) Piedmont West Urgent Care Center, L.L.C.
- (c) Sutton Road Pediatrics, L.L.C.

(b) Physician Performance Network, L.L.C.

- (c) Physician Performance Network of Georgia, L.L.C.
- (c) Physician Performance Network of Philadelphia, L.L.C.

(b) Professional Healthcare Systems Licensing Corporation
(b) Roswell Medical Ventures, Inc.

- (c) North Fulton Parking Deck, L.P. *— ownership — Roswell Medical Ventures, Inc. (89.836%), other outside partners (10.164%)*

(b) Sierra Vista Hospital, Inc.
(b) South Carolina Health Services, Inc.

- (c) Bluffton Okatie Primary Care, L.L.C.
- (c) Broad River Primary Care, L.L.C.
- (c) Burnt Church Primary and Urgent Care, L.L.C.
- (c) Cardiovascular & Thoracic Surgery Associates, L.L.C.
- (c) Okatie Surgical Partners, L.L.C.
- (c) Hardeeville Hospitalists, L.L.C.

(c) Heritage Medical Group of Hilton Head, L.L.C.
(c) Hilton Head Occupational Medicine, L.L.C.
(c) Hilton Head Regional Anesthesia Partners, L.L.C.
(c) Hilton Head Regional Endocrinology Associates, L.L.C.
(c) Hilton Head Regional OB/GYN Partners, L.L.C.
(c) Mid-Island Primary and Urgent Care, L.L.C.
(c) Nephrology Associates of Hilton Head, L.L.C.
(c) Oncology Associates of the Low Country, L.L.C.
(c) Orthopedic Associates of the Lowcountry, L.L.C.
(c) Tenet Hilton Head Heart, L.L.C.
(c) Tenet South Carolina Lowcountry OB/GYN, L.L.C.

(b) Tenet Central Carolina Physicians, Inc.
(b) Tenet DISC Imaging, Inc.
(b) Tenet EKG, Inc.
(b) Tenet Finance Corp.
(b) Tenet Good Samaritan, Inc.
(c) Good Samaritan Surgery, L.L.C.
(c) Good Samaritan Cardiac & Vascular Management, LLC — *ownership — Tenet Good Samaritan, Inc. (50%); other outside physician partners (50%)*

(b) Tenet HealthSystem Bartlett, Inc.
(b) Tenet HealthSystem GB, Inc.
(c) AMC Acquisition Company, L.L.C.
(c) AMC Community Physician Practices, L.L.C.
(c) Atlanta Medical Billing Center, L.L.C.
(c) Sheffield Educational Fund, Inc.
(c) Tenet South Fulton Health Care Centers, Inc.

(b) Tenet HealthSystem Nacogdoches ASC GP, Inc.
(c) NMC Lessor, L.P. — *ownership — GP: Tenet HealthSystem Nacogdoches ASC GP, Inc. (1%); LP: TH Healthcare, Ltd. (99%)*
(c) NMC Surgery Center, L.P. — *ownership — Tenet HealthSystem Nacogdoches ASC GP, Inc. (1% GP); Tenet HealthSystem Nacogdoches ASC, LP, Inc. (58.999% LP); other outside partners (49.001% LP)*

(b) Tenet HealthSystem Nacogdoches ASC LP, Inc.
(b) Tenet HealthSystem North Shore, Inc.
(c) North Shore Medical Billing Center, L.L.C.
(c) North Shore Physician Hospital Organization *(50%)*
(c) North Shore Physician Practices, L.L.C.

(b) Tenet HealthSystem Philadelphia, Inc.
(c) HPS of PA, L.L.C.
(c) Tenet HealthSystem Bucks County, L.L.C.
(c) Tenet HealthSystem City Avenue, L.L.C.
(c) Tenet HealthSystem Elkins Park, L.L.C.
(c) Tenet HealthSystem Graduate, L.L.C.
(c) Tenet HealthSystem Hahnemann, L.L.C.
(c) Tenet HealthSystem Parkview, L.L.C.
(c) Tenet HealthSystem Roxborough, LLC
(c) Tenet HealthSystem Roxborough MOB, LLC
(c) Tenet HealthSystem St. Christopher's Hospital for Children, L.L.C.
(d) Center for the Urban Child, Inc.
(d) SCHC Pediatric Anesthesia Associates, L.L.C.
(d) SCHC Pediatric Associates, L.L.C.
(e) St. Christopher's Pediatric Urgent Care Center, L.L.C.
(e) St. Christopher's Pediatric Urgent Care Center - Allentown, L.L.C.
(d) StChris Care at Northeast Pediatrics, L.L.C.
(c) Tenet Home Services, L.L.C.
(c) Tenet Medical Equipment Services, L.L.C.
(c) The Healthcare Underwriting Company, a Risk Retention Group
(c) TPS of PA, L.L.C.

(d) TPS II of PA, L.L.C.
(d) TPS III of PA, L.L.C.
(d) TPS IV of PA, L.L.C.
(d) TPS V of PA, L.L.C.
(d) TPS VI of PA, L.L.C.
(c) MidAtlantic MedEvac, L.L.C.
(b) Tenet HealthSystem SGH, Inc.
(b) Tenet HealthSystem SL, Inc.
(c) SLUH Anesthesia Physicians, L.L.C.
(c) Tenet SLUH Physicians, L.L.C.
(b) Tenet HealthSystem SL-HLC, Inc.
(b) Tenet HealthSystem Spalding, Inc.
(c) Griffin Imaging, LLC — *ownership — Tenet HealthSystem Spalding, Inc., managing member (50.5%); other outside members (49.5%)*
(c) Spalding GI, L.L.C.
(c) Spalding Health System, L.L.C. — *ownership — (49.836%)*
(c) Spalding Medical Ventures, L.P.
(c) Tenet EMS/Spalding 911, LLC — *ownership — (64.1%)*
(b) Tenet Healthcare - Florida, Inc.
(b) Tenet Investments, Inc.
(b) Tenet Physician Services - Hilton Head, Inc.
(b) Tenet Practice Resources, LLC
(b) Tenet St. Mary's, Inc.
(c) The Heart and Vascular Clinic, L.L.C.
(b) Tenet Ventures, Inc.
(b) Tenet West Palm Real Estate, Inc.
(c) G.S. North, Ltd. — *ownership — (1% GP and 93.03% LP*)

Tenet HealthSystem Hospitals, Inc.
(a) Alvarado Hospital Medical Center, Inc.

Tenet HealthSystem HealthCorp
(a) OrNda Hospital Corporation
(b) AHM Acquisition Co., Inc.
(b) Commonwealth Continental Health Care, Inc.
(b) Coral Gables Hospital, Inc.
(c) CGH Hospital, Ltd. — *ownership — GP: Coral Gables Hospital, Inc. (99.913%) LP: FMC Medical, Inc. (0.087%)*
(d) Coral Gables Physician Services, L.L.C.
(d) Universal Medical Care Center, L.L.C.
(b) Cypress Fairbanks Medical Center, Inc.
(c) New Medical Horizons II, Ltd. — *ownership — GP: Cypress Fairbanks Medical Center, Inc. (5%) LP: Tenet HealthSystem CFMC, Inc. (95%)*
(b) FMC Medical, Inc.
(b) Fountain Valley Regional Hospital and Medical Center
(c) Specialty Surgery Center at Fountain Valley Regional Hospital, L.L.C. — *ownership — Fountain Valley Regional Hospital and Medical Center (51%); other outside members (49%)*
(b) GCPG, Inc.
(c) Garland MOB Properties, LLC
(b) Gulf Coast Community Hospital, Inc.
(c) Gulf Coast Community Health Care Systems, Inc.
(b) Houston Northwest Medical Center, Inc.
(c) HNMC, Inc.
(d) HNW GP, Inc.
(e) Houston Northwest Partners, Ltd. — *ownership — GP: HNW GP, Inc. (1%) LP: HNW LP, Inc. (99%)*

(f) Conroe Surgery Center 2, LLC — *ownership — Houston Northwest Partners, Ltd. managing member (50.89%); other outside members (49.11%)*
(f) Houston Northwest Operating Company, L.L.C. — *ownership — Houston Northwest Partners, Ltd. (86.69%); other outside members (13.31%)*
(g) Houston Northwest Concessions, L.L.C.
(f) Northwest Surgery Center, Ltd — *ownership — Houston Northwest Partners, Ltd. (51%); other outside partners (49%)*
(d) HNW LP, Inc.
(c) Northwest Houston Providers Alliance, Inc.
(b) Newhope Imaging Center, Inc.
(b) NWSC, L.L.C.
(b) Republic Health Corporation of Rockwall County
(c) Lake Pointe GP, Inc.
(d) Lake Pointe Partners, Ltd. — *ownership — GP: Lake Pointe GP, Inc. (1%); LP: Lake Pointe Investments, Inc. (99%)*
(e) Lake Pointe Operating Company, L.L.C. — *ownership — Lake Pointe Partners, Ltd. (94.674%); other outside members (5.326%)*
(f) Billing Center Lake Pointe Medical, L.L.C.
(c) Lake Pointe ASC GP, Inc.
(c) Lake Pointe Investments, Inc.
(d) Lake Pointe Rockwall ASC, LP — *ownership — GP: Lake Pointe Rockwall ASC GP, Inc. (1%); LP: Lake Pointe Investments, Inc. (99%)*
(b) RHC Parkway, Inc.
(c) North Miami Medical Center, Ltd. — *ownership — RHC Parkway, Inc. (85.91%) Commonwealth Continental Health Care, Inc. (14.09%)*
(b) Saint Vincent Healthcare System, Inc.
(c) OHM Services, Inc.
(c) Saint Vincent Hospital, L.L.C.
(b) SHL/O Corp.
(b) Tenet HealthSystem CFMC, Inc.
(b) Tenet HealthSystem CM, Inc.
(a) Tenet MetroWest Healthcare System, Limited Partnership

Tenet HealthSystem International, Inc.
(a) N.M.E. International (Cayman) Limited
(b) HUG Services, Inc. — *ownership — N.M.E. International (Cayman) Limited (67%); Tenet Healthcare Corporation (30%); Tenet HealthSystem Medical, Inc. (3%)*
(c) Captive Insurance Services, Inc.
(c) Hospital Underwriting Group, Inc.
(d) Professional Liability Insurance Company
(a) The Healthcare Insurance Corporation

Tenet Hospitals, Inc.
(a) National ASC, Inc.
(a) Tenet Alabama, Inc.
(b) Brookwood Primary Network Care, Inc.
(c) Alabama Cardiovascular Associates, L.L.C.
(c) Alabama Hand and Sports Medicine, L.L.C.
(c) Brookwood - Maternal Fetal Medicine, L.L.C.
(c) Brookwood Medical Partners - ENT, L.L.C.
(c) Brookwood Occupational Health Clinic, L.L.C.
(c) Brookwood Primary Care Cahaba Heights, L.L.C.
(c) Brookwood Primary Care - Homewood, L.L.C.
(c) Brookwood Primary Care Hoover, L.L.C.
(c) Brookwood Primary Care - Inverness, L.L.C.
(c) Brookwood Primary Care - Mountain Brook, L.L.C.
(c) Brookwood Primary Care - Oak Mountain, L.L.C.
(c) Brookwood Primary Care - Red Mountain, L.L.C.
(c) Brookwood Primary Care The Narrows, L.L.C.

- (c) Brookwood Primary Care - Trussville, L.L.C.
- (c) Brookwood Primary Care - Vestavia, L.L.C.
- (c) Brookwood Primary Care Network - McCalla, L.L.C.
- (c) Brookwood Sports and Orthopedics, L.L.C.
- (c) Brookwood Specialty Care - Endocrinology, L.L.C.
- (c) Brookwood Women's Care, L.L.C.
- (c) Cardiovascular Associates of the Southeast, L.L.C.
- (c) Greystone Internal Medicine - Brookwood, L.L.C.
- (c) Norwood Clinic of Alabama, L.L.C.
- (b) Brookwood Retail Pharmacy, L.L.C.

(a) Tenet California, Inc.
- (b) Anaheim MRI Holding, Inc.
- (b) Community Hospital of Los Gatos, Inc.
  - (c) Los Gatos Multi-Specialty Group, Inc.
- (b) Doctors Hospital of Manteca, Inc.
- (b) Doctors Medical Center of Modesto, Inc.
  - (c) Modesto On-Call Services, L.L.C.
  - (c) Modesto Radiology Imaging, Inc.
  - (c) Yosemite Medical Clinic, Inc.
- (b) First Choice Physician Partners
- (b) Golden State Medicare Health Plan
- (b) JFK Memorial Hospital, Inc.
  - (c) SSC Holdings, L.L.C.
- (b) Lakewood Regional Medical Center, Inc.
- (b) Los Alamitos Medical Center, Inc.
  - (c) Reagan Street Surgery Center, L.L.C. — *ownership — Los Alamitos Medical Center, Inc (52%); other outside members (48%)*
- (b) National Medical Ventures, Inc.
- (b) Network Management Associates, Inc.
- (b) PHPS-CHM Acquisition, Inc.
  - (c) Coast Healthcare Management, LLC
  - (c) Premier Health Plan Services, Inc.
- (b) Placentia-Linda Hospital, Inc.
  - (c) Anaheim Hills Medical Imaging, L.L.C.
- (b) San Ramon ASC, L.P.
- (b) San Ramon Surgery Center, L.L.C.
- (b) SRRMC Management, Inc.
  - (c) San Ramon Network Joint Venture, LLC — *ownership — SRRMC Management, Inc (51%); John Muir Health (49%)*
    - (d) San Ramon Ambulatory Care, LLC
  - (c) San Ramon Regional Medical Center, LLC — *ownership — SRRMC Management, Inc (51%); John Muir Health (49%)*
    - (d) Pleasanton Diagnostic Imaging, Inc.
- (b) Tenet California Nurse Resources, Inc.
- (b) Tenet California Medical Ventures I, Inc.
- (b) Tenet El Mirador Surgical Center, Inc.
- (b) Tenet HealthSystem Desert, Inc.
- (b) Tenet HealthSystem KNC, Inc.
- (b) Twin Cities Community Hospital, Inc.
  - (c) Templeton Imaging, Inc.

(a) Tenet Florida, Inc.
- (b) Advantage Health Network, Inc. — *ownership — Tenet Florida, Inc. (50%); other outside members (50%)*
- (b) Delray Medical Center, Inc.
- (b) Florida Regional Medical Center, Inc.
- (b) FMCC Network Contracting, L.L.C.
- (b) FREH Real Estate, L.L.C.
- (b) FRS Imaging Services, L.L.C.
- (b) Hollywood Medical Center, Inc.

- (b) International Health and Wellness, Inc.
- (b) National Medical Services II, Inc.
- (b) National Urgent Care, Inc.
- (b) Tenet Florida Physician Services, L.L.C.
  - (c) Center for Advanced Research Excellence, L.L.C.
  - (c) Sunrise Medical Group I, L.L.C.
  - (c) Sunrise Medical Group II, L.L.C.
  - (c) Sunrise Medical Group III, L.L.C.
  - (c) Sunrise Medical Group IV, L.L.C.
  - (c) Sunrise Medical Group V, L.L.C.
  - (c) Sunrise Medical Group VI, L.L.C.
  - (c) Tenet Florida Physician Services II, L.L.C.
  - (c) Tenet Florida Physician Services III, L.L.C.
- (b) Tenet Hialeah HealthSystem, Inc.
  - (c) Hialeah Real Properties, Inc.
  - (c) Tenet Hialeah (ASC) HealthSystem, Inc.
- (b) Tenet Network Management, Inc.
- (b) West Boca Medical Center, Inc.
  - (c) West Boca Health Services, L.L.C.

(a) Tenet Georgia, Inc.
- (b) AMC Neurosurgical Associates, L.L.C.
- (b) Atlanta Medical Center Interventional Neurology Associates, L.L.C.
- (b) Atlanta Medical Center Neurosurgical & Spine Specialists, L.L.C.
- (b) Atlanta Medical Center Physician Group, L.L.C.
- (b) Buckhead Orthopedic Surgery Center, L.L.C.
- (b) Gastric Health Institute, L.L.C.
- (b) Georgia Gifts From Grace, L.L.C.
- (b) Georgia North Fulton Healthcare Associates, L.L.C.
- (b) Georgia Northside Ear, Nose and Throat, L.L.C.
- (b) Georgia Spectrum Neurosurgical Specialists, L.L.C.
- (b) Jackson Medical Center, L.L.C.
- (b) North Fulton Cardiovascular Medicine, L.L.C.
- (b) North Fulton Hospitalist Group, L.L.C.
- (b) North Fulton Primary Care Associates, L.L.C.
- (b) North Fulton Primary Care - Windward Parkway, L.L.C.
- (b) North Fulton Primary Care - Wylie Bridge, L.L.C.
- (b) North Fulton Pulmonary Specialists, L.L.C.
- (b) North Fulton Regional Medical Center Pro Fee Billing, L.L.C.
- (b) North Fulton Women's Consultants, L.L.C.
- (b) Rock Bridge Surgical Institute, L.L.C.
- (b) Roswell Orthopedic Specialists, L.L.C.
- (b) Rheumatology Associates of Atlanta Medical Center, L.L.C.
- (b) Spalding Regional Ambulatory Surgery Center, L.L.C.
- (b) Spalding Regional OB/GYN, L.L.C.
- (b) Spalding Regional Physician Services, L.L.C.
- (b) Spalding Regional Urgent Care Center at Heron Bay, L.L.C.
- (b) SouthCare Physicians Group Neurology, L.L.C.
- (b) SouthCare Physicians Group Obstetrics & Gynecology, L.L.C.
- (b) South Fulton Regional Medical Center Pro Fee Billing, L.L.C.
- (b) Surgical & Bariatric Associates of Atlanta Medical Center, L.L.C.

(a) Total Health PPO, Inc. — o*wnership — Tenet Hospitals, Inc (49%); HealthScope (51%)*

(a) Tenet Louisiana, Inc.
- (b) Meadowcrest Hospital, LLC
- (b) Meadowcrest Multi-Specialty Clinic, L.L.C.
- (b) Tenet 100 Medical Center Slidell, L.L.C.
- (b) Tenet HealthSystem Memorial Medical Center, Inc.
  - (c) Tenet Mid-City Medical, LLC

(a) Tenet Missouri, Inc.

- (b) Cedar Hill Primary Care, L.L.C.
- (b) Premier Emergency Physicians, L.L.C.
- (b) Premier Medical Specialists, L.L.C.
- (b) St. Louis University Hospital Ambulatory Surgery Center, L.L.C.
- (b) Tenet HealthSystem DI, Inc.
  - (c) Bridgeton Imaging, L.L.C.
  - (c) U.S. Center for Sports Medicine, L.L.C.
- (a) Tenet Nebraska, Inc.
- (a) Tenet North Carolina, Inc.
  - (b) Cardiology Physicians Associates, L.L.C.
  - (b) Cardiology Physicians Corporation, L.L.C.
  - (b) Central Carolina-CIM, L.L.C.
  - (b) Central Carolina-IMA, L.L.C.
  - (b) Central Carolina Hospital Pro Fee Billing, L.L.C.
  - (b) Central Carolina Physicians - Sandhills, L.L.C.
  - (b) FryeCare Appalachian, L.L.C.
  - (b) FryeCare Boone, L.L.C.
  - (b) FryeCare Morganton, L.L.C.
  - (b) FryeCare Northwest Hickory, L.L.C.
  - (b) FryeCare Physicians, L.L.C.
  - (b) FryeCare Valdese, L.L.C.
  - (b) FryeCare Watauga, L.L.C.
  - (b) FryeCare Women's Services, L.L.C.
  - (b) Frye Physicians - Tenet NC, L.L.C.
  - (b) Graystone Family Healthcare - Tenet North Carolina, L.L.C.
  - (b) Hallmark Family Physicians - Tenet North Carolina, L.L.C.
  - (b) Healthpoint of North Carolina, L.L.C.
  - (b) Hickory Family Practice Associates - Tenet North Carolina, L.L.C.
  - (b) North Carolina Community Family Medicine, L.L.C.
  - (b) Parkway Internal Medicine - Tenet North Carolina, L.L.C.
  - (b) Southern States Physician Operations, Inc.
  - (b) Tenet Claremont Family Medicine, L.L.C.
  - (b) Tenet Unifour Urgent Care Center, L.L.C.
  - (b) Viewmont Internal Medicine - Tenet North Carolina, L.L.C.
- (a) Tenet Physicians, Inc.
- (a) Tenet South Carolina, Inc.
  - (b) East Cooper Coastal Family Physicians, L.L.C.
  - (b) East Cooper Hyperbarics, L.L.C.
  - (b) East Cooper OBGYN, L.L.C.
  - (b) East Cooper Primary Care Physicians, L.L.C.
  - (b) Hilton Head Hospital Pro Fee Billing, L.L.C.
  - (b) Hilton Head Regional Healthcare, L.L.C.
  - (b) South Carolina East Cooper Surgical Specialists, L.L.C.
  - (b) South Carolina SeWee Family Medicine, L.L.C.
  - (b) Southern Orthopedics and Sports Medicine, L.L.C.
  - (b) Tenet Fort Mill, Inc.
  - (b) Tenet SC East Cooper Hospitalists, L.L.C.
  - (b) Tenet South Carolina Gastrointestinal Surgical Specialists, L.L.C.
  - (b) Tenet South Carolina Island Medical, L.L.C.
  - (b) Tenet South Carolina Mt. Pleasant OB/GYN, L.L.C.
- (a) Tenet Tennessee, Inc.
  - (b) Saint Francis Behavioral Health Associates, L.L.C.
  - (b) Saint Francis Cardiology Associates, L.L.C.
  - (b) Saint Francis Cardiovascular Surgery, L.L.C.
  - (b) Saint Francis Center for Surgical Weight Loss, L.L.C.
  - (b) Saint Francis Hospital Inpatient Physicians, L.L.C.
  - (b) Saint Francis Hospital Pro Fee Billing, L.L.C.
  - (b) Saint Francis Medical Partners, East, L.L.C.

(b) Saint Francis Medical Specialists, L.L.C.
(b) Saint Francis Surgical Associates, L.L.C.
(a) Tenet Texas, Inc.
(b) Eastside ASC GP, Inc.
(c) Eastside Surgery, L.P.
(b) EPHC, Inc.
(b) Greater Dallas Healthcare Enterprises
(b) Greater Northwest Houston Enterprises
(b) Houston Sunrise Investors, Inc.
(b) National Ancillary, Inc.
(b) National HHC, Inc.
(b) National ICN, Inc.
(b) Physicians Performance Network of Houston
(b) Practice Partners Management, L.P. — *ownership — GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(b) Sierra Providence Healthcare Enterprises
(b) Sierra Providence Health Network, Inc.
(b) Tenet El Paso, Ltd. — ownership — *GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(b) Tenet Frisco, Ltd. — *ownership — GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(b) Tenet HealthSystem Hospitals Dallas, Inc.
(b) Tenet Hospitals Limited — *ownership — GP: Tenet Texas, Inc. (1%); LP: Tenetsub Texas, Inc. (99%)*
(c) Billing Center Doctors Hospital at White Rock Lake, L.L.C.
(c) PDN, L.L.C.
(d) Surgery Affiliate of El Paso, LLC — *ownership — PDN, LLC, managing member (61%); other outside members (39%)*
(c) Tenet Sun View Imaging, L.L.C.
(b) Tenet Relocation Services, L.L.C.
(b) Tenetsub Texas, Inc.

T.I. GPO, Inc.

Vanguard Health Systems, Inc.
(a) Vanguard Health Holding Company I, LLC
(b) Vanguard Holding Company I, Inc.
(b) Vanguard Health Holding Company II, LLC
(c) Vanguard Health Management, Inc.
(d) Harbor Health Plans, Inc.
(d) Vanguard Health Financial Company, LLC
(e) C7 Technologies, LLC
(e) Central Texas Corridor Hospital Company, LLC
(e) Hospital Development of West Phoenix, Inc.
(e) MacNeal Management Services, Inc.
(f) Chicago Health System ACO, LLC
(f) MacNeal Health Providers, Inc.
(f) Midwest Pharmacies, Inc.
(f) Primary Care Physicians Center, LLC - *ownership - MacNeal Management Services, Inc. (94% of capital interests) and Thomas Mizen (6% of capital interests)*
(f) Pros Temporary Staffing, Inc.
(f) The 6300 West Roosevelt Partnership - *ownership - MacNeal Management Services, Inc. 50.326% (29.876% GP interest and 20.450% LP interest) and numerous limited partners*
(f) Watermark Physician Services, Inc.
(e) MacNeal Medical Records, Inc.
(e) Resolute Hospital Company, LLC
(e) Southwest Children's Hospital, LLC
(e) V-II Acquisition Co., Inc.
(e) Valley Baptist Insurance Company

(e) Vanguard IT Services, LLC
(e) VHS Acquisition Corporation
(e) VHS Acquisition Subsidiary Number 1, Inc.
(e) VHS Acquisition Subsidiary Number 2, Inc.
(e) VHS Acquisition Subsidiary Number 3, Inc.
  (f) LakeFront Medical Associates, LLC
(e) VHS Acquisition Subsidiary Number 4, Inc.
(e) VHS Acquisition Subsidiary Number 5, Inc. - *ownership - Vanguard Health Financial Company, LLC (100% voting common - 8,010 common shares) and Baptist Health Foundation of San Antonio (3,582 preferred)*
  (f) VHS San Antonio Imaging Partners, L.P. - *ownership - VHS Acquisition Subsidiary Number 5, Inc. General Partner (2%), Imaging Center Partners, L.P., Limited Partner (50%) and VHS San Antonio Partners, LLC, Limited Partner (48%)*
  (f) VHS San Antonio Partners, LLC - *ownership - VHS Acquisition Subsidiary Number 5, Inc., Managing Member (2%) and VHS Holding Company, Inc. (98%)*
    (g) Baptist Medical Management Service Organization, LLC
    (g) BHS Accountable Care, LLC
    (g) BHS Integrated Physician Partners, LLC
    (g) BHS Physicians Alliance For ACE, LLC
    (g) Home Health Partners of San Antonio, LLC
      (h) Journey Home Healthcare of San Antonio, LLC
(e) VHS Acquisition Subsidiary Number 6, Inc.
  (f) VHS Acquisition Partnership Number 1, L.P. - *ownership - VHS Acquisition Subsidiary Number 6, Inc., General Partner (2%) and VHS Holding Company, Inc., Limited Partner (98%)*
(e) VHS Acquisition Subsidiary Number 7, Inc.
  (f) Saint Vincent Physician Services, Inc.
(e) VHS Acquisition Subsidiary Number 8, Inc.
  (f) Community Connection Health Plan, Inc.
  (f) Advantage Health Care Management Company, LLC
(e) VHS Acquisition Subsidiary Number 9, Inc.
  (f) MetroWest Accountable Health Care Organization, LLC - *ownership - VHS Acquisition Subsidiary Number 9, Inc. (50%) and MetroWest Health Care Alliance, Inc. (50%)*
    (g) Total Accountable Care Organization, LLC - *ownership - MetroWest Accountable Health Care Organization, LLC (70%) and VHS Acquisition Subsidiary Number 7, Inc. (30%)*
  (f) VHM Services, Inc.
(e) VHS Acquisition Subsidiary Number 10, Inc.
(e) VHS Acquisition Subsidiary Number 11, Inc.
(e) VHS Acquisition Subsidiary Number 12, Inc.
(e) VHS Genesis Labs, Inc.
(e) VHS Holding Company, Inc.
  (f) BHS Physicians Network, Inc.
  (f) BHS Specialty Network, Inc.
    (g) Heart & Vascular Institute of Texas, Inc.
  (f) Resolute Health Family Urgent Care, Inc.
  (f) Resolute Health Physicians Network, Inc.
(e) VHS Imaging Centers, Inc.
(e) VHS New England Holding Company I, Inc.
(e) VHS of Illinois, Inc.
  (f) HCM/CV, LLC - *ownership - VHS of Illinois, Inc. (50%), HeartCare Centers of Illinois, S.C. (25%) and Cardiac Surgery Associates, S.C. (25%)*
  (f) MacNeal Physicians Group, LLC
  (f) Vanguard Medical Specialists, LLC
  (f) VHS Chicago Market Procurement, LLC
(e) VHS of Michigan, Inc.
  (f) CRNAS of Michigan

(f) Detroit Education and Research
(f) DMC Education & Research
(f) Heart & Vascular Institute of Michigan
(f) Southeast Michigan Physicians Insurance Company
(f) VHS Children's Hospital of Michigan, Inc.
(f) VHS Detroit Businesses, Inc.
(f) VHS Detroit Receiving Hospital, Inc.
(f) VHS Detroit Ventures, Inc.
(g) DMC Shared Savings ACO, LLC
(g) Michigan Pioneer ACO, LLC - *ownership - VHS Detroit Ventures, Inc. (99.875%), George E. Evans (0.25%), Murtaza Hussain (0.25%), Muhammad Y. Karim (0.25%), Michael G. Taylor (0.25%) and Carl D. Fowler (0.25%)*
(f) VHS Harper-Hutzel Hospital, Inc.
(f) VHS Huron Valley-Sinai Hospital, Inc.
(f) VHS of Michigan Staffing, Inc.
(f) VHS Physicians of Michigan
(f) VHS Rehabilitation Institute of Michigan, Inc.
(f) VHS Sinai-Grace Hospital, Inc.
(f) VHS University Laboratories, Inc.

(e) VHS of Orange County, Inc.
(f) VHS Acquisition Partnership Number 2, L.P. - *ownership - VHS of Orange County, Inc., General Partner (1%), VHS of Orange County, Inc., Limited Partner (58.4%), VHS Holding Company, Inc., Limited Partner (35%), Physician Investors, Limited Partners (5.6%)*
(f) VHS of Anaheim, Inc.
(g) North Anaheim Surgicenter, Ltd. - *ownership - VHS of Anaheim, Inc., General Partner (76.5%) and Physician Investors, Limited Partners (23.5%)*
(f) VHS of Huntington Beach, Inc.
(g) Magnolia Surgery Center Limited Partnership - *ownership - VHS of Huntington Beach, Inc., General Partner (1%), VHS Holding Company, Inc., Limited Partner (82.6%) and Third Parties (physicians), Limited Partner (16.4%)*

(e) VHS of Phoenix, Inc.
(f) VHS Arizona Heart Institute, Inc.
(f) VHS of Arrowhead, Inc.
(f) VHS of South Phoenix, Inc.
(g) Arizona Health Partners, LLC
(g) Palm Valley Medical Center Campus Association - *ownership - VHS of South Phoenix, Inc. (72.38%), Palm Valley Med Bldg L.P. (Plaza) (5.72%), Palm Valley Med Bldg L.P. (Ruiz) (12.60%) and Palm Valley Nursing Facility L.P. (Nursing Home) (9.30%)*
(g) Phoenix Health Plans, Inc.
(h) VHS Phoenix Health Plan, LLC
(g) VHS Acquisition Company Number 1, LLC - *ownership - VHS of South Phoenix, Inc. (60%) and Medical Professional Associates of Arizona, P.C. (40%)*
(f) VHS Outpatient Clinics, Inc.
(g) Abrazo Medical Group Urgent Care, LLC

(e) VHS Valley Management Company, Inc.
(f) Harlingen Physician Network, Inc.
(f) Rio Grande Valley Indigent Health Care Corporation
(f) Valley Health Care Network
(f) VHS Valley Health System, LLC - *ownership - VHS Valley Management Company, Inc., Manager (51%) and VB Medical Holdings (49%)*
(g) VHS Brownsville Hospital Company, LLC
(g) VHS Harlingen Hospital Company, LLC
(g) Valley Baptist Realty Company, LLC
(g) VHS Valley Holdings, LLC
(h) Valley Baptist Lab Services, LLC
(h) Valley Baptist Wellness Center, LLC

(h) VB Brownsville IMP ASC, LLC
(h) VB Brownsville LTACH, LLC
(h) VBOA ASC GP, LLC
(i) VBOA ASC Partners, L.P. - *ownership - VBOA ASC GP, LLC General Partner (1%), Various physicians, Class A Limited Partners (38%) and VB Brownsville IMP ASC, LLC, Class B Limited Partner (61%)*

(e) VHS West Suburban Medical Center, Inc.
(f) West Suburban Radiation Therapy Center, LLC
(e) VHS Westlake Hospital, Inc.
(e) VHS-Volunteer Insurance Ltd. (Cayman Islands Company)

(d) Vanguard Physician Services, LLC - *ownership - Vanguard Health Management, Inc. (60%) and MedSynergies, Inc. (40%)*
(d) Healthcare Compliance, L.L.C.
(d) New Dimensions, LLC

(c) Vanguard Holding Company II, Inc.

Wilshire Rental Corp.

(a) Hitchcock State Street Real Estate, Inc.

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement Nos. 33-55285, 33-57801, 333-21867, 333-24955, 333-26621, and 333-185162 on Form S-3, Registration Statement No. 333-191613 on Form S-4, and Registration Statement Nos. 33-57375, 333-00709, 333-01183, 333-38299, 333-41903, 333-41476, 333-41478, 333-48482, 333-74216, 333-151884, 333-151887, 333-166767, 333-166768 and 333-191614 on Form S-8 of our reports dated February 24, 2014, relating to the consolidated financial statements and financial statement schedule of Tenet Healthcare Corporation and subsidiaries, and the effectiveness of Tenet Healthcare Corporation and subsidiaries' internal control over financial reporting, appearing in this Annual Report on Form 10-K of Tenet Healthcare Corporation for the year ended December 31, 2013.

/s/ Deloitte & Touche LLP

Dallas, Texas
February 24, 2014

Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Trevor Fetter, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 24, 2014

/s/ TREVOR FETTER

Trevor Fetter

President and Chief Executive Officer

Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this annual report on Form 10-K of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: February 24, 2014

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

Exhibit 32

Certifications Pursuant to Section 1350 of Chapter 63
of Title 18 of the United States Code

We, the undersigned Trevor Fetter and Daniel J. Cancelmi, being, respectively, the President and Chief Executive Officer and the Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Annual Report on Form 10-K for the year ended December 31, 2013 (the "Form 10-K"), to be filed with the Securities and Exchange Commission on the date hereof, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and (ii) the information contained in the Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: February 24, 2014

/s/ TREVOR FETTER
Trevor Fetter
President and Chief Executive Officer

Date: February 24, 2014

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 13: TENET 2014 3RD QUARTER 10-Q

FORM 10-Q

TENET HEALTHCARE CORP - THC

Filed: November 03, 2014 (period: September 30, 2014)

Quarterly report with a continuing view of a company's financial position

Table of Contents

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 September 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 October 31, 2014, there were 98,280,152 shares of the Registrant's common stock, $0.05 par value, outstanding.

Table of Contents

TENET HEALTHCARE CORPORATION
TABLE OF CONTENTS

		Page
PART I. FINANCIAL INFORMATION		
Item 1.	Financial Statements (Unaudited)	
	Condensed Consolidated Financial Statements	1
	Notes to Condensed Consolidated Financial Statements	5
Item 2.	Management's Discussion and Analysis of Financial Condition and Results of Operations	24
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	59
Item 4.	Controls and Procedures	60
PART II. OTHER INFORMATION		
Item 1.	Legal Proceedings	61
Item 1A.	Risk Factors	61
Item 6.	Exhibits	62

Table of Contents

PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
Dollars in Millions
(Unaudited)

	September 30, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 200	$ 113
Accounts receivable, less allowance for doubtful accounts ($773 at September 30, 2014 and $589 at December 31, 2013)	2,238	1,890
Inventories of supplies, at cost	270	260
Income tax receivable	22	—
Current portion of deferred income taxes	725	692
Other current assets	746	737
Total current assets	**4,201**	**3,692**
Investments and other assets	366	357
Deferred income taxes, net of current portion	100	148
Property and equipment, at cost, less accumulated depreciation and amortization ($4,347 at September 30, 2014 and $3,907 at December 31, 2013)	7,749	7,582
Goodwill	3,705	3,566
Other intangible assets, at cost, less accumulated amortization ($623 at September 30, 2014 and $516 at December 31, 2013)	1,191	1,105
Total assets	**$ 17,312**	**$ 16,450**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 98	$ 153
Accounts payable	1,068	1,085
Accrued compensation and benefits	735	622
Professional and general liability reserves	175	156
Accrued interest payable	265	198
Other current liabilities	804	879
Total current liabilities	**3,145**	**3,093**
Long-term debt, net of current portion	11,455	10,696
Professional and general liability reserves	525	555
Defined benefit plan obligations	381	398
Other long-term liabilities	544	490
Total liabilities	**16,050**	**15,232**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	396	340
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 145,421,213 shares issued at September 30, 2014 and 144,057,351 shares issued at December 31, 2013	7	7
Additional paid-in capital	4,597	4,572
Accumulated other comprehensive loss	(20)	(24)
Accumulated deficit	(1,471)	(1,422)
Common stock in treasury, at cost, 47,196,935 shares at September 30, 2014 and 47,197,722 shares at December 31, 2013	(2,378)	(2,378)
Total shareholders' equity	**735**	**755**
Noncontrolling interests	**131**	**123**
Total equity	**866**	**878**
Total liabilities and equity	**$ 17,312**	**$ 16,450**

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues:				
Net operating revenues before provision for doubtful accounts	$ 4,428	$ 2,618	$ 13,096	$ 7,841
Less: Provision for doubtful accounts	249	210	949	624
Net operating revenues	**4,179**	**2,408**	**12,147**	**7,217**
Operating expenses:				
Salaries, wages and benefits	2,028	1,172	5,905	3,499
Supplies	665	387	1,942	1,158
Other operating expenses, net	1,032	575	3,066	1,710
Electronic health record incentives	(5)	(14)	(72)	(48)
Depreciation and amortization	207	119	609	354
Impairment and restructuring charges, and acquisition-related costs	37	20	90	45
Litigation and investigation costs	4	1	19	3
Operating income	**211**	**148**	**588**	**496**
Interest expense	(186)	(91)	(558)	(292)
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Investment earnings	—	—	—	1
Net income (loss) from continuing operations, before income taxes	**1**	**57**	**6**	**(143)**
Income tax benefit (expense)	18	(16)	11	57
Net income (loss) from continuing operations, before discontinued operations	**19**	**41**	**17**	**(86)**
Discontinued operations:				
Loss from operations	(2)	(8)	(17)	(5)
Litigation and investigation costs	—	(2)	(18)	(2)
Income tax benefit	1	5	13	3
Net loss from discontinued operations	**(1)**	**(5)**	**(22)**	**(4)**
Net income (loss)	**18**	**36**	**(5)**	**(90)**
Less: Net income attributable to noncontrolling interests	9	8	44	20
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ 9**	**$ 28**	**$ (49)**	**$ (110)**
Amounts attributable to Tenet Healthcare Corporation common shareholders				
Net income (loss) from continuing operations, net of tax	$ 10	$ 33	$ (27)	$ (106)
Net loss from discontinued operations, net of tax	(1)	(5)	(22)	(4)
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ 9**	**$ 28**	**$ (49)**	**$ (110)**
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic				
Continuing operations	$ 0.10	$ 0.33	$ (0.27)	$ (1.03)
Discontinued operations	(0.01)	(0.05)	(0.23)	(0.04)
	$ 0.09	**$ 0.28**	**$ (0.50)**	**$ (1.07)**
Diluted				
Continuing operations	$ 0.10	$ 0.32	$ (0.27)	$ (1.03)
Discontinued operations	(0.01)	(0.05)	(0.23)	(0.04)
	$ 0.09	**$ 0.27**	**$ (0.50)**	**$ (1.07)**
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	98,036	100,894	97,625	102,669
Diluted	100,926	103,098	97,625	102,669

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME
Dollars in Millions
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net income (loss)	$ 18	$ 36	$ (5)	$ (90)
Other comprehensive income:				
Amortization of prior-year service costs included in net periodic benefit costs	1	—	4	—
Unrealized gains (losses) on securities held as available-for-sale	(1)	—	2	—
Other comprehensive income before income taxes	**—**	**—**	**6**	**—**
Income tax expense related to items of other comprehensive income	—	—	(2)	—
Total other comprehensive income, net of tax	**—**	**—**	**4**	**—**
Comprehensive net income (loss)	**18**	**36**	**(1)**	**(90)**
Less: Comprehensive income attributable to noncontrolling interests	**9**	**8**	**44**	**20**
Comprehensive net income (loss) attributable to Tenet Healthcare Corporation common shareholders	**$ 9**	**$ 28**	**$ (45)**	**$ (110)**

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions
(Unaudited)

	Nine Months Ended September 30,	
	2014	2013
Net loss	**$ (5)**	**$ (90)**
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	609	354
Provision for doubtful accounts	949	624
Deferred income tax benefit	(22)	(60)
Stock-based compensation expense	41	26
Impairment and restructuring charges, and acquisition-related costs	90	45
Litigation and investigation costs	19	3
Loss from early extinguishment of debt	24	348
Amortization of debt discount and debt issuance costs	21	12
Pre-tax loss from discontinued operations	35	7
Other items, net	(16)	(19)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(1,309)	(662)
Inventories and other current assets	12	(159)
Income taxes	(7)	(5)
Accounts payable, accrued expenses and other current liabilities	120	(44)
Other long-term liabilities	38	(5)
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(115)**	**(36)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(16)**	**(5)**
Net cash provided by operating activities	**468**	**334**
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(734)	(398)
Purchases of businesses or joint venture interests, net of cash acquired	(185)	(142)
Proceeds from sales of facilities and other assets — discontinued operations	4	11
Proceeds from sales of marketable securities, long-term investments and other assets	2	6
Other long-term assets	(4)	11
Other items, net	3	3
Net cash used in investing activities	**(914)**	**(509)**
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(1,965)	(1,001)
Proceeds from borrowings under credit facility	1,560	1,211
Repayments of other borrowings	(655)	(1,987)
Proceeds from other borrowings	1,608	1,907
Repurchases of common stock	—	(300)
Deferred debt issuance costs	(26)	(31)
Distributions paid to noncontrolling interests	(30)	(18)
Contributions from noncontrolling interests	15	98
Proceeds from exercise of stock options	23	22
Other items, net	3	(8)
Net cash provided by (used in) financing activities	**533**	**(107)**
Net increase (decrease) in cash and cash equivalents	87	(282)
Cash and cash equivalents at beginning of period	113	364
Cash and cash equivalents at end of period	**$ 200**	**$ 82**
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (487)	$ (295)
Income tax payments, net	$ (5)	$ (5)

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

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 September 30, 2014, we operated 80 hospitals, 198 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). The accompanying Condensed Consolidated Balance Sheet as of December 31, 2013 was derived from the audited consolidated financial statements included in our Annual Report, but has been revised to reflect the impact of completing the purchase price allocation for the acquisition of Vanguard, as described in Note 14. Additionally, 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 nine months ended September 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 September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
General Hospitals:				
Medicare	$ 838	$ 501	$ 2,560	$ 1,543
Medicaid	340	206	1,012	630
Managed care	2,369	1,378	6,787	4,126
Indemnity, self-pay and other	357	262	1,172	783
Acute care hospitals — other revenue	8	14	45	53
Other:				
Other operations	516	257	1,520	706
Net operating revenues before provision for doubtful accounts	**$ 4,428**	**$ 2,618**	**$ 13,096**	**$ 7,841**

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 $200 million and $113 million at September 30, 2014 and December 31, 2013, respectively. As of September 30, 2014 and December 31, 2013, our book overdrafts were approximately $194 million and $245 million, respectively, which were classified as accounts payable.

At September 30, 2014 and December 31, 2013, approximately $98 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 September 30, 2014 and December 31, 2013, we had $113 million and $193 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $62 million and $138 million, respectively, were included in accounts payable.

During the nine months ended September 30, 2014 and 2013, we entered into non-cancellable capital leases of approximately $112 million and $99 million, respectively, primarily for buildings and equipment.

Table of Contents

Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets as of September 30, 2014 and December 31, 2013:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of September 30, 2014:			
Capitalized software costs	$ 1,326	$ (552)	$ 774
Long-term debt issuance costs	245	(42)	203
Trade names	106	—	106
Contracts	57	(5)	52
Other	80	(24)	56
Total	**$ 1,814**	**$ (623)**	**$ 1,191**

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2013:			
Capitalized software costs	$ 1,148	$ (468)	$ 680
Long-term debt issuance costs	230	(31)	199
Trade names	106	—	106
Contracts	57	(2)	55
Other	80	(15)	65
Total	**$ 1,621**	**$ (516)**	**$ 1,105**

Estimated future amortization of intangibles with finite useful lives as of September 30, 2014 is as follows:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Amortization of intangible assets	$ 1,077	$ 54	$ 190	$ 163	$ 134	$ 130	$ 406

NOTE 2. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

The principal components of accounts receivable are shown in the table below:

	September 30, 2014	December 31, 2013
Continuing operations:		
Patient accounts receivable	$ 2,978	$ 2,459
Allowance for doubtful accounts	(772)	(589)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	122	92
Net cost reports and settlements payable and valuation allowances	(92)	(75)
	2,236	1,887
Discontinued operations	2	3
Accounts receivable, net	**$ 2,238**	**$ 1,890**

As of September 30, 2014 and December 31, 2013, our allowance for doubtful accounts was 25.9% and 24.0%, respectively, of our patient accounts receivable. 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 September 30, 2014 and December 31, 2013, our allowance for doubtful accounts for self-pay was 79.5% and 75.9%, respectively, of our self-pay

patient accounts receivable, including co-pays and deductibles owed by patients with insurance. As of September 30, 2014 and December 31, 2013, our allowance for doubtful accounts for managed care was 6.2% and 5.9%, 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 September 30, 2014 and 2013 were approximately $135 million and $116 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $488 million and $342 million, respectively. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the three months ended September 30, 2014 and 2013 were approximately $42 million and $32 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $137 million and $95 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 September 30, 2014 and 2013 were approximately $178 million and $72 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $493 million and $257 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 loss before income taxes reported in discontinued operations are as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	$ 1	$ 3	$ 2	$ 6
Net loss before income taxes	(2)	(10)	(35)	(7)

Net loss before income taxes from discontinued operations in the nine months ended September 30, 2014 included 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 nine months ended September 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 nine months ended September 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $90 million, consisting of $14 million of employee severance costs, $6 million of contract and lease termination fees, $19 million of restructuring costs, and $51 million in acquisition-related costs, which include $7 million of transaction costs and $44 million of acquisition integration charges.

During the nine months ended September 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $45 million, consisting of $2 million relating to the impairment of property, $10 million of restructuring costs, $9 million of employee severance costs, $1 million in lease termination fees, and $23 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 September 30, 2014, our continuing operations consisted of two operating segments, our hospital and other operations and our Conifer subsidiary. During the three months ended March 31, 2014, we combined our

California region and our Phoenix market to form our Western region. Our hospital and other operations are currently structured as follows:

- Our Central region includes all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the Resolute Health, 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 Resolute Health market includes our hospital and other operations in the New Braunfels, Texas area;
- Our San Antonio market includes all of our hospitals and other operations in the San Antonio, Texas area; and
- Our South Texas market includes all of our hospitals and other operations in the Brownsville and Harlingen, Texas areas.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

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.

Table of Contents

NOTE 5. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of September 30, 2014 and December 31, 2013:

	September 30, 2014	December 31, 2013
Senior notes:		
9 7/8%, due 2014	$ —	$ 60
9 1/4%, due 2015	—	474
5%, due 2019	1,100	—
5 1/2%, due 2019	500	—
6 3/4%, due 2020	300	300
8%, due 2020	750	750
8 1/8%, due 2022	2,800	2,800
6 7/8%, due 2031	430	430
Senior secured notes:		
6 1/4%, due 2018	1,041	1,041
4 3/4%, due 2020	500	500
6%, due 2020	1,800	1,800
4 1/2%, due 2021	850	850
4 3/8%, due 2021	1,050	1,050
Credit facility due 2016	—	405
Capital leases and mortgage notes	453	417
Unamortized note discounts and premium	(21)	(28)
Total long-term debt	**11,553**	**10,849**
Less current portion	98	153
Long-term debt, net of current portion	**$ 11,455**	**$ 10,696**

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 September 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 September 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 September 30, 2014, we had approximately $115 million of standby letters of credit outstanding under the LC Facility.

Senior Notes

In September 2014, we sold $500 million aggregate principal amount of 5 1/2% 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 March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

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, which payments commenced 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. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs. The net 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 September 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 $92 million. We had a liability of $69 million recorded for these guarantees included in other current liabilities at September 30, 2014.

NOTE 7. EMPLOYEE BENEFIT PLANS

At September 30, 2014, approximately 5.2 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 nine months ended September 30, 2014 and 2013 includes $38 million and $29 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements recorded in salaries, wages and benefits in the accompanying Condensed Consolidated Statements of Operations.

Table of Contents

Stock Options

The following table summarizes stock option activity during the nine months ended September 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	—			
Exercised	(691,050)	33.72		
Forfeited/Expired	(624,052)	47.97		
Outstanding as of September 30, 2014	**1,993,009**	**$ 24.40**	**$ 70**	**3.9 years**
Vested and expected to vest at September 30, 2014	**1,984,562**	**$ 24.31**	**$ 70**	**3.9 years**
Exercisable as of September 30, 2014	**1,587,878**	**$ 21.90**	**$ 60**	**3.7 years**

There were 691,050 stock options exercised during the nine months ended September 30, 2014 with a $13 million aggregate intrinsic value, and 913,369 stock options exercised during the same period in 2013 with a $17 million aggregate intrinsic value.

As of September 30, 2014, there were $2 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 1.1 years.

There were no stock options granted in the nine months ended September 30, 2014. In the nine months ended September 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 nine months ended September 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:

	Nine Months Ended September 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 September 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	242,753	4.4 years	$ 4.56	242,753	$ 4.56
$4.57 to $25.089	957,583	5.2 years	20.96	830,903	20.67
$25.09 to $32.569	402,816	1.9 years	29.32	402,816	29.32
$32.57 to $42.089	389,857	2.5 years	40.10	111,406	42.08
	1,993,009	**3.9 years**	**$ 24.40**	**1,587,878**	**$ 21.90**

Restricted Stock Units

The following table summarizes restricted stock unit activity during the nine months ended September 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	1,768,508	48.41
Vested	(900,763)	36.51
Forfeited	(140,468)	35.23
Unvested as of September 30, 2014	**3,434,499**	**$ 41.85**

In the nine months ended September 30, 2014, we granted 1,045,750 restricted stock units subject to time-vesting of which 944,249 will vest and be settled ratably over a three-year period from the date of the grant, 23,435 will vest 100% on the tenth anniversary of the grant date, 63,623 will vest 100% on the fifth anniversary of the grant date and 14,443 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. We also granted 450,943 special retention restricted stock units to a select group of officers; two-thirds of the award will vest contingent on our achievement of a performance goal of which one-half will vest based on performance over a one-year period ending in December 2015 and the remaining one-half will vest based on performance over a four-year period ending in December 2018. The remaining one-third of this special retention award will vest in full on the fifth anniversary of the grant date.

In the nine months ended September 30, 2013, we granted 815,262 restricted stock units subject to time-vesting, of which 735,129 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 September 30, 2014, there were $107 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 3.0 years.

Table of Contents

NOTE 8. EQUITY

Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the nine months ended September 30, 2014 and 2013 (dollars in millions, share amounts in thousands):

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock							
	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, 2013	**96,860**	**$ 7**	**$ 4,572**	**$ (24)**	**$ (1,422)**	**$ (2,378)**	**$ 123**	**$ 878**
Net income (loss)	—	—	—	—	(49)	—	20	(29)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(27)	(27)
Contributions from noncontrolling interests	—	—	—	—	—	—	5	5
Other comprehensive income	—	—	—	4	—	—	—	4
Purchases (sales) of businesses or joint venture interests	—	—	(22)	—	—	—	10	(12)
Stock-based compensation expense and issuance of common stock	1,364	—	47	—	—	—	—	47
Balances at September 30, 2014	**98,224**	**$ 7**	**$ 4,597**	**$ (20)**	**$ (1,471)**	**$ (2,378)**	**$ 131**	**$ 866**
Balances at December 31, 2012	**104,633**	**$ 7**	**$ 4,471**	**$ (68)**	**$ (1,288)**	**$ (1,979)**	**$ 75**	**$ 1,218**
Net income (loss)	—	—	—	—	(110)	—	13	**(97)**
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(16)	(16)
Sales of joint venture interests	—	—	53	—	—	—	—	53
Purchases of businesses or joint venture interests	—	—	—	—	—	—	23	23
Repurchase of common stock	(7,095)	—	—	—	—	(300)	—	(300)
Stock-based compensation expense and issuance of common stock	1,628	—	38	—	—	1	—	39
Balances at September 30, 2013	**99,166**	**$ 7**	**$ 4,562**	**$ (68)**	**$ (1,398)**	**$ (2,278)**	**$ 95**	**$ 920**

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 nine months ended September 30, 2014 and 2013:

	Nine Months Ended September 30,	
	2014	2013
Balances at beginning of period	**$ 340**	**$ 16**
Net income	24	7
Distributions paid to noncontrolling interests	(3)	(2)
Contributions from noncontrolling interests	10	—
Sales of joint venture interests	—	52
Purchases of businesses	25	10
Balances at end of period	**$ 396**	**$ 83**

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 September 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 $700 million and $711 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 2.22% at September 30, 2014 and 2.45% at December 31, 2013.

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 $170 million and $71 million for the nine months ended September 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. 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. In September 2014, subject to negotiation of final settlement terms, we reached a verbal financial agreement with the government to settle this matter with respect to the remaining five hospitals for approximately $2 million, which has been fully reserved as of September 30, 2014.

- *Implantable Cardioverter Defibrillators ("ICDs")*—We are engaged in potential settlement discussions with the DOJ to resolve an investigation to determine whether ICD procedures performed at 56 of our hospitals from 2002 to 2010 complied with Medicare coverage requirements. It is impossible at this time to predict with any certainty the outcome of those discussions or the amount of any potential resolution. However, 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 for all of the hospitals under review as part of the government's examination, which commenced in March 2010.

- *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. The parties have agreed to stay discovery in the case until March 31, 2015.

  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. It is impossible at this time to predict with any certainty the amount and terms of any potential resolution of these matters; however, we believe the amount of the reserve established continues to reflect our current estimate of probable liability. 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. Management has established reserves of approximately $38 million in the aggregate for our potential 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 October 2014, we received court approval of a final agreement 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 between January 15 and March 31, 2015. The settlement will be funded in amounts and on a schedule to be agreed to by the parties. 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 nine months ended September 30, 2014 and 2013:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Balances at End of Period
Nine Months Ended September 30, 2014				
Continuing operations	$ 64	$ 19	$ (10)	$ 73
Discontinued operations	6	18	(6)	18
	$ 70	**$ 37**	**$ (16)**	**$ 91**
Nine Months Ended September 30, 2013				
Continuing operations	$ 5	$ 3	$ (3)	$ 5
Discontinued operations	5	2	(1)	6
	$ 10	**$ 5**	**$ (4)**	**$ 11**

For the nine months ended September 30, 2014 and 2013, we recorded costs of $37 million and $5 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

NOTE 11. INCOME TAXES

During the nine months ended September 30, 2014, we recorded a net income tax benefit of $11 million, which includes, among other things: (1) $3 million of income tax expense to increase our valuation allowance for deferred tax assets; (2) $7 million of income tax benefit related to tax basis adjustments for state tax purposes on the Vanguard acquisition; (3) $4 million of income tax benefit related to certain amended state tax returns; and (4) $4 million of income tax benefit related to other tax adjustments. The increase in the valuation allowance relates to an estimated decrease in the future utilization of certain state net operating loss carryovers.

During the nine months ended September 30, 2014, we reduced our estimated liabilities for uncertain tax positions by $3 million, net of related deferred tax assets. The total amount of unrecognized tax benefits as of September 30, 2014 was $40 million, of which $31 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 September 30, 2014 were $5 million, all of which related to continuing operations.

As of September 30, 2014, approximately $2 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 earnings (loss) per common share calculations for net income (loss) from continuing operations for the three and nine months ended September 30, 2014 and 2013. Net income (loss) is expressed in millions and weighted average shares are expressed in thousands.

	Net Income (Loss) (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended September 30, 2014			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 10	98,036	$ 0.10
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,890	—
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 10**	**100,926**	**$ 0.10**
Three Months Ended September 30, 2013			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 33	100,894	$ 0.33
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,204	(0.01)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 33**	**103,098**	**$ 0.32**
Nine Months Ended September 30, 2014			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (27)	97,625	$ (0.27)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (27)**	**97,625**	**$ (0.27)**
Nine Months Ended September 30, 2013			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (106)	102,669	$ (1.03)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ (106)**	**102,669**	**$ (1.03)**

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the nine months ended September 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 2,332 for the nine months ended September 30, 2014 and 827 for the nine months ended September 30, 2013.

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 September 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	September 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	$ —	$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
Marketable debt securities — noncurrent	62	26	35	1
	$ 66	**$ 28**	**$ 37**	**$ 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	$ —	$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
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 September 30, 2014 and December 31, 2013, the estimated fair value of our long-term debt was approximately 103.8% and 103.5%, respectively, of the carrying value of the debt.

NOTE 14. ACQUISITIONS

During the nine months ended September 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, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. We also acquired four 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 $185 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.

Preliminary purchase price allocations for the acquisitions made during the nine months ended September 30, 2014 are as follows:

Current assets	$ 19
Property and equipment	104
Goodwill	137
Current liabilities	(21)
Long-term liabilities	(19)
Redeemable noncontrolling interests	(21)
Noncontrolling interests	(14)
Net cash paid	**$ 185**

The goodwill generated from these transactions, the majority of which will be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and increased reimbursement. Approximately $7 million in transaction costs related to prospective and closed acquisitions were expensed during the nine months ended September 30, 2014, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statement of Operations.

Acquisition of Vanguard

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, 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. We have completed the analysis required to finalize the purchase price allocation for this acquisition and related disclosures. We have revised our Condensed Consolidated Balance Sheet as of December 31, 2013 to reflect the impact of these adjustments.

The purchase price allocation for our Vanguard acquisition is as follows:

Current assets	$	976
Property and equipment		2,830
Other long term assets		152
Other intangible assets		155
Goodwill		2,460
Current liabilities		(1,193)
Deferred taxes-long term		(103)
Other long-term liabilities		(3,711)
Redeemable noncontrolling interests in equity of consolidated subsidiaries		(258)
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 acquisition had occurred at the beginning of the year ended December 31, 2013:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	**$ 4,179**	**$ 3,748**	**$ 12,147**	**$ 11,574**
Net income (loss) from continuing operations, before income taxes	**$ 1**	**$ (220)**	**$ 6**	**$ (418)**

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 September 30, 2014, our subsidiaries operated 80 hospitals, with a total of 20,762 licensed beds, primarily serving urban and suburban communities, as well as 198 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 September 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 78% of Conifer's net operating revenues for the nine months ended September 30, 2014 and 2013, respectively.

The following tables include 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:

	September 30, 2014	December 31, 2013
Assets:		
Hospital operations and other	$ 16,988	$ 16,194
Conifer	324	256
Total	**$ 17,312**	**$ 16,450**

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Capital expenditures:				
Hospital operations and other	$ 207	$ 139	$ 717	$ 387
Conifer	4	3	17	11
Total	**$ 211**	**$ 142**	**$ 734**	**$ 398**
Net operating revenues:				
Hospital operations and other	$ 4,031	$ 2,275	$ 11,707	$ 6,840
Conifer				
Tenet	148	92	426	278
Other customers	148	133	440	377
	4,327	2,500	12,573	7,495
Intercompany eliminations	(148)	(92)	(426)	(278)
Total	**$ 4,179**	**$ 2,408**	**$ 12,147**	**$ 7,217**
Adjusted EBITDA:				
Hospital operations and other	$ 412	$ 252	$ 1,167	$ 802
Conifer	47	36	139	96
Total	**$ 459**	**$ 288**	**$ 1,306**	**$ 898**
Depreciation and amortization:				
Hospital operations and other	$ 202	$ 114	$ 594	$ 339
Conifer	5	5	15	15
Total	**$ 207**	**$ 119**	**$ 609**	**$ 354**
Adjusted EBITDA	**$ 459**	**$ 288**	**$ 1,306**	**$ 898**
Depreciation and amortization	(207)	(119)	(609)	(354)
Impairment and restructuring charges, and acquisition-related costs	(37)	(20)	(90)	(45)
Litigation and investigation costs	(4)	(1)	(19)	(3)
Interest expense	(186)	(91)	(558)	(292)
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Investment earnings	—	—	—	1
Net income (loss) from continuing operations before income taxes	**$ 1**	**$ 57**	**$ 6**	**$ (143)**

Table of Contents

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

Acquisition of Revenue Cycle Services for Physician Practices—In October 2014, Conifer acquired SPi Healthcare, a provider of revenue cycle management, health information management and software solutions for independent and provider-owned physician practices. The base purchase price was $235 million. We have not yet finalized the analysis required to complete the purchase price allocation for this acquisition and the related disclosures.

Table of Contents

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 through 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 nine months ended September 30, 2014, and (iii) Resolute Health Hospital, a newly constructed facility opened in June 2014, Texas Regional Medical Center at Sunnyvale, in which we acquired a majority interest in June 2014, and Emanuel Medical Center, which we acquired in August 2014, in each case only for the period of time from such opening or acquisition to September 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 nine months ended September 30, 2014 and 2013, but excludes the results of (i) legacy Vanguard operations, (ii) Resolute Health Hospital, Texas Regional Medical Center and Emanuel 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

Acquisition of Revenue Cycle Services for Physician Practices—In October 2014, Conifer acquired SPi Healthcare, a provider of revenue cycle management, health information management and software solutions for independent and provider-owned physician practices. We believe the combined organization will drive incremental growth for Conifer in the physician revenue cycle marketplace.

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 markets where we believe our operating strategies can improve performance and create shareholder value. Most recently, 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 nine months ended September 30, 2014, we also acquired four 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 nine months ended September 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 services 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 employers and other entities. In October 2014, Conifer acquired SPi Healthcare, which is expected to drive Conifer's incremental growth in the areas of revenue cycle management, health information management and software solutions services for independent and provider-owned physician practices.

Realizing HIT Incentive Payments and Other Benefits—Beginning in the year ended December 31, 2011, we began achieving 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 nine months ended September 30, 2014, we recognized approximately $72 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. We believe our volumes were positively impacted in the nine months ended September 30, 2014 by incremental market share we generated through 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. We believe our 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. For example, 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 began 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 and the Risk Factors section in Part II of this report.

RESULTS OF OPERATIONS—OVERVIEW

Selected Operating Statistics for All Continuing Operations Hospitals—The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the 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, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014, in each case only for the period of time from such acquisition or opening to September 30, 2014. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase in the scale of our operations as a result of these investments.

	Total Hospital Continuing Operations Three Months Ended September 30,		
	2014	2013	Increase (Decrease)
Total admissions	199,914	121,569	64.4 %
Adjusted patient admissions[1]	345,787	196,761	75.7 %
Paying admissions (excludes charity and uninsured)	188,924	112,760	67.5 %
Charity and uninsured admissions	10,990	8,809	24.8 %
Admissions through emergency department	123,147	75,512	63.1 %
Emergency department visits	719,835	400,345	79.8 %
Total emergency department admissions and visits	842,982	475,857	77.2 %
Surgeries — inpatient	55,339	34,971	58.2 %
Surgeries — outpatient	123,100	76,084	61.8 %
Total surgeries	178,439	111,055	60.7 %
Patient days — total	921,228	569,833	61.7 %
Adjusted patient days[1]	1,574,346	912,483	72.5 %
Average length of stay (days)	4.61	4.69	(1.7)%
Average licensed beds	20,692	13,180	57.0 %
Utilization of licensed beds[2]	48.4 %	47.0 %	1.4 %[3]
Total visits	2,125,002	1,071,421	98.3 %
Paying visits (excludes charity and uninsured)	1,954,980	956,871	104.3 %
Charity and uninsured visits	170,022	114,550	48.4 %
Net inpatient revenues	$ 2,463	$ 1,502	64.0 %
Net outpatient revenues	$ 1,441	$ 845	70.5 %
Net inpatient revenue per admission	$ 12,320	$ 12,355	(0.3)%
Net inpatient revenue per patient day	$ 2,674	$ 2,636	1.4 %
Net outpatient revenue per visit	$ 678	$ 789	(14.1)%
Net patient revenue per adjusted patient admission[1]	$ 11,290	$ 11,928	(5.3)%
Net patient revenue per adjusted patient day[1]	$ 2,480	$ 2,572	(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 amounts shown for the three months ended September 30, 2014 compared to the three months ended September 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 September 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, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014.

	Same-Hospital Continuing Operations Three Months Ended September 30,		
Admissions, Patient Days and Surgeries	2014	2013	Increase (Decrease)
Total admissions	127,118	121,569	4.6 %
Adjusted patient admissions[1]	208,229	196,761	5.8 %
Paying admissions (excludes charity and uninsured)	118,580	112,760	5.2 %
Charity and uninsured admissions	8,538	8,809	(3.1)%
Admissions through emergency department	80,328	75,512	6.4 %
Paying admissions as a percentage of total admissions	93.3 %	92.8 %	0.5 %[2]
Charity and uninsured admissions as a percentage of total admissions	6.7 %	7.2 %	(0.5)%[2]
Emergency department admissions as a percentage of total admissions	63.2 %	62.1 %	1.1 %[2]
Surgeries — inpatient	35,570	34,971	1.7 %
Surgeries — outpatient	91,472	76,084	20.2 %
Total surgeries	127,042	111,055	14.4 %
Patient days — total	594,664	569,833	4.4 %
Adjusted patient days[1]	962,054	912,483	5.4 %
Average length of stay (days)	4.68	4.69	(0.2)%
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	13,231	13,180	0.4 %
Utilization of licensed beds[3]	48.9 %	47.0 %	1.9 %[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 September 30, 2014 compared to the three months ended September 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 5,549, or 4.6%, in the three months ended September 30, 2014 compared to the three months ended September 30, 2013. Total surgeries increased by 14.4% in the three months ended September 30, 2014 compared to the same period in 2013, comprised of a 20.2% increase in outpatient surgeries primarily due to our outpatient development strategies and a 1.7% increase in inpatient surgeries. Our emergency department admissions increased 6.4% in the three months ended September 30, 2014 compared to the same period in the prior year. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the ACA, and a strengthening economy. Charity and uninsured admissions decreased 3.1% in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 primarily due to Medicaid expansion in California and health insurance exchange coverage under the ACA.

Outpatient Visits	Same-Hospital Continuing Operations Three Months Ended September 30, 2014	2013	Increase (Decrease)
Total visits	1,155,852	1,071,421	7.9 %
Paying visits (excludes charity and uninsured)	1,042,636	956,871	9.0 %
Charity and uninsured visits	113,216	114,550	(1.2)%
Emergency department visits	433,174	400,345	8.2 %
Surgery visits	91,472	76,084	20.2 %
Paying visits as a percentage of total visits	90.2 %	89.3 %	0.9 %[1]
Charity and uninsured visits as a percentage of total visits	9.8 %	10.7 %	(0.9)%[1]

(1) The change is the difference between the amounts shown for the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Total same-hospital outpatient visits increased 84,431, or 7.9%, in the three months ended September 30, 2014 compared to the three months ended September 30, 2013, which included 9.0% growth for paying visits. Approximately 81% of the growth in outpatient visits was organic.

Outpatient surgery visits increased by 20.2% in the three months ended September 30, 2014 compared to the same period in 2013. Charity and uninsured outpatient visits decreased by 1.2% in the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Revenues	Same-Hospital Continuing Operations Three Months Ended September 30, 2014	2013	Increase (Decrease)
Net operating revenues	$ 2,684	$ 2,408	11.5 %
Revenues from the uninsured	$ 150	$ 167	(10.2)%
Net inpatient revenues[1]	$ 1,602	$ 1,502	6.7 %
Net outpatient revenues[1]	$ 924	$ 845	9.3 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $56 million and $68 million for the three months ended September 30, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $94 million and $99 million for the three months ended September 30, 2014 and 2013, respectively.

Net operating revenues increased by $276 million, or 11.5%, on a same-hospital basis in the three months ended September 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 10.2% in the three months ended September 30, 2014 compared to the three months ended September 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 September 30, 2014 included $74 million of Medicaid disproportionate share hospital ("DSH") and other state-funded subsidy revenues compared to $72 million in the same period in 2013 on a same-hospital basis. During the three months ended September 30, 2013, we recognized $19 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 September 30, 2014 because the current program has not been approved by CMS yet. Net patient revenues increased by 7.6% in the three months ended September 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 September 30, 2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 12,602	$ 12,355	2.0 %
Net inpatient revenue per patient day	$ 2,694	$ 2,636	2.2 %
Net outpatient revenue per visit	$ 799	$ 789	1.3 %
Net patient revenue per adjusted patient admission[1]	$ 12,131	$ 11,928	1.7 %
Net patient revenue per adjusted patient day[1]	$ 2,626	$ 2,572	2.1 %

(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 and net outpatient revenue per visit increased 2.0% and 1.3%, respectively, in the three months ended September 30, 2014 compared to the same period in 2013. The increases were primarily due to improved terms of our managed care contracts.

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Three Months Ended September 30, 2014	2013	Increase (Decrease)
Provision for doubtful accounts	$ 163	$ 210	(22.4)%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	5.7 %	8.0 %	(2.3)%[1]
Collection rate on self-pay accounts[2]	27.5 %	28.8 %	(1.3)%[1]
Collection rate on commercial managed care accounts	98.3 %	98.3 %	— %[1]

(1) The change is the difference between the amounts shown for the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

Provision for doubtful accounts decreased by $47 million, or 22.4%, in the three months ended September 30, 2014 compared to the same period in 2013. The decrease in the provision for doubtful accounts primarily related to the decrease in revenues from the uninsured and the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the 130 basis point decrease in our self-pay collection rate, as well as higher patient co-pays and deductibles. Our self-pay collection rate, which is the blended collection rate for uninsured and balance after insurance accounts receivable, was approximately 27.5% at September 30, 2014 and 28.8% at September 30, 2013.

Selected Operating Expenses	Same-Hospital Continuing Operations Three Months Ended September 30, 2014	2013	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,150	$ 1,032	11.4 %
Supplies	416	387	7.5 %
Other operating expenses	587	526	11.6 %
Total	$ 2,153	$ 1,945	10.7 %
Conifer			
Salaries, wages and benefits	$ 182	$ 140	30.0 %
Other operating expenses	67	49	36.7 %
Total	$ 249	$ 189	31.7 %
Total			
Salaries, wages and benefits	$ 1,332	$ 1,172	13.7 %
Supplies	416	387	7.5 %
Other operating expenses	654	575	13.7 %
Total	$ 2,402	$ 2,134	12.6 %
Rent/lease expense[1]			
Hospital Operations and other	$ 37	$ 41	(9.8)%
Conifer	5	3	66.7 %
Total	$ 42	$ 44	(4.5)%
Hospital Operations and other[2]			
Salaries, wages and benefits per adjusted patient day	$ 1,193	$ 1,130	5.6 %
Supplies per adjusted patient day	432	424	1.9 %
Other operating expenses per adjusted patient day	593	565	5.0 %
Total per adjusted patient day	$ 2,218	$ 2,119	4.7 %
Salaries, wages and benefits per adjusted patient admission	$ 5,513	$ 5,240	5.2 %
Supplies per adjusted patient admission	1,998	1,967	1.6 %
Other operating expenses per adjusted patient admission	2,737	2,622	4.4 %
Total per adjusted patient admission	$ 10,248	$ 9,829	4.3 %

(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 4.7% and 4.3% on a per adjusted patient day and per adjusted patient admission basis, respectively, in the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Salaries, wages and benefits per adjusted patient admission increased by approximately 5.2% in the three months ended September 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 September 30, 2014 compared to the three months ended September 30, 2013.

Supplies expense per adjusted patient admission increased by 1.6% in the three months ended September 30, 2014 compared to the three months ended September 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 4.4% in the three months ended September 30, 2014 compared to the same period in 2013. This change is due to increased costs of contracted services,

higher medical fees primarily related to a greater number of employed and contracted physicians, increased malpractice expense and increased costs associated with funding indigent care services by certain of our Texas hospitals, which were substantially offset by additional net patient revenues. Malpractice expense in the 2014 period included a favorable adjustment of approximately $1 million due to a nine basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $2 million as a result of a six basis point increase in the interest rate in the 2013 period.

Salaries, wages and benefits expense for Conifer increased by $42 million in the three months ended September 30, 2014 compared to the three months ended September 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 $18 million in the three months ended September 30, 2014 compared to the three months ended September 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 nine months ended September 30, 2014 and 2013 of the following items:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (37)	$ (20)	$ (90)	$ (45)
Litigation and investigation costs	(4)	(1)	(19)	(3)
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Pre-tax impact	$ (65)	$ (21)	$ (133)	$ (396)
Other tax adjustments	$ 14	$ —	$ 18	$ (6)
Total after-tax impact	$ (26)	$ (13)	$ (66)	$ (255)
Diluted per-share impact of above items	$ (0.26)	$ (0.13)	$ (0.68)	$ (2.45)
Diluted earnings per share, including above items	$ 0.10	$ 0.32	$ (0.27)	$ (1.03)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $200 million at September 30, 2014, a decrease of $206 million from $406 million at June 30, 2014.

Significant cash flow items in the three months ended September 30, 2014 included:

- $221 million of cash provided by operations;
- Capital expenditures of $211 million;
- Purchases of businesses for $143 million;
- Interest payments of $127 million;
- $493 million of net proceeds from the issuance of our $5^1/_2$% senior notes due 2019;
- $60 million of payments on our $9^7/_8$% senior notes due 2014; and
- $497 of net payments to redeem our $9^1/_4$% senior notes due 2015.

Net cash provided by operating activities was $468 million in the nine months ended September 30, 2014 compared to $334 million in the nine months ended September 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 $408 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 nine months ended September 30, 2014 compared to the nine months ended September 30, 2013;
- $11 million more cash used in operating activities from discontinued operations;
- An increase of $79 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- Higher interest payments of $192 million.

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 and the Risk Factors section in Part II of this 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 September 30,			Nine Months Ended September 30,		
Net Patient Revenues from:	2014	2013	Increase (Decrease)[1]	2014	2013	Increase (Decrease)[1]
Medicare	21.5 %	21.3 %	0.2 %	22.2 %	21.8 %	0.4 %
Medicaid	8.7 %	8.8 %	(0.1)%	8.8 %	8.9 %	(0.1)%
Managed care	60.7 %	58.8 %	1.9 %	58.8 %	58.2 %	0.6 %
Indemnity, self-pay and other	9.1 %	11.1 %	(2.0)%	10.2 %	11.1 %	(0.9)%

(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 September 30,			Nine Months Ended September 30,		
Admissions from:	2014	2013	Increase (Decrease)[1]	2014	2013	Increase (Decrease)[1]
Medicare	26.6 %	27.1 %	(0.5)%	27.6 %	28.2 %	(0.6)%
Medicaid	9.9 %	12.6 %	(2.7)%	10.8 %	12.1 %	(1.3)%
Managed care	56.1 %	49.6 %	6.5 %	53.9 %	49.3 %	4.6 %
Indemnity, self-pay and other	7.4 %	10.7 %	(3.3)%	7.7 %	10.4 %	(2.7)%

(1) The increase (decrease) is the difference between the 2014 and 2013 percentages shown.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services is the single largest payer of healthcare services in the United States. Nearly 90 million Americans rely on healthcare benefits through Medicare, Medicaid, and the Children's Health Insurance Program ("CHIP"). These three major programs are authorized by federal law and directed by CMS, an agency of the U.S. Department of Health and Human Services ("HHS"). Medicare is a federally funded 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 administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP is also administered by the states and jointly funded and provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

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. Earlier this year, 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 September 30, 2014, 27 states and the District of Columbia have taken action to expand Medicaid and two others are considering action to expand in the near future. We currently operate hospitals in five of the states that have expanded in 2014 and one of the states that is expanding in 2015. 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, which began for Medicare payments in federal fiscal year ("FFY") 2014 and will begin for 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 nine months ended September 30, 2014 and 2013 are set forth in the following table:

Revenue Descriptions	Three Months Ended September 30, 2014[1]	Three Months Ended September 30, 2013	Nine Months Ended September 30, 2014[1]	Nine Months Ended September 30, 2013
Medicare severity-adjusted diagnosis-related group — operating	$ 407	$ 252	$ 1,248	$ 807
Medicare severity-adjusted diagnosis-related group — capital	37	22	114	70
Outliers	16	12	52	37
Outpatient	234	138	710	408
Disproportionate share	96	51	287	157
Direct Graduate and Indirect Medical Education[2]	55	24	186	76
Other[3]	30	6	55	19
Adjustments for prior-year cost reports and related valuation allowances	(1)	18	18	34
Total Medicare net patient revenues	**$ 874**	**$ 523**	**$ 2,670**	**$ 1,608**

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center, Resolute Health Hospital and Emanuel Medical Center.
(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.

Medicare Hospital Appeals Settlement

During the three months ended September 30, 2014, CMS offered hospitals an opportunity to settle certain Medicare inpatient claims in the appeals process or within the timeframe to request an appeal. Generally, the one-time settlement offer applies to payment denials for inpatient services on the basis that the services were reasonable and necessary, but treatment as an inpatient was not. All of our hospitals with claims that are eligible for settlement are accepting the settlement offer. The estimated cash value of the settlement for our hospitals' claims is approximately $18 million.

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 17.4% and 15.7% of net patient revenues before provision for doubtful accounts at our continuing general hospitals for the nine months ended September 30, 2014 and 2013, respectively. We also receive DSH payments under various state Medicaid programs. For the nine months ended September 30, 2014 and 2013, our revenues attributable to DSH payments and other state-funded subsidy payments for our continuing operations were approximately $493 million and $257 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 nine months ended September 30, 2014 and 2013 are set forth in the table below:

	Nine Months Ended September 30,			
	2014[1]		2013	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Michigan	$ 253	$ 197	$ —	$ —
Texas	208	174	84	93
Florida	134	68	136	47
California	108	180	188	123
Illinois	62	23	—	—
Georgia	57	27	60	25
Pennsylvania	57	145	55	148
Missouri	51	6	49	5
Massachusetts	28	35	—	—
North Carolina	22	6	25	3
South Carolina	12	23	18	19
Alabama	10	—	10	—
Arizona	5	87	—	—
Tennessee	5	22	5	21
	$ 1,012	**$ 993**	**$ 630**	**$ 484**

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center, Resolute Health Hospital and Emanuel Medical Center.

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.

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 August 4, 2014, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2015 Rates, and, on October 3, 2014, CMS issued a Correction Notice to the August 4, 2014 rule (together, the "Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.9% 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 making certain adjustments to the estimated 2.9% market basket increase that result in a net market basket update of 1.4% (before budget neutrality adjustments), including:
  - Market basket index and multifactor productivity reductions required by the ACA of 0.2% and 0.5%, respectively; and
  - A documentation and coding recoupment reduction of 0.8% as 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 1.32% net increase in the capital federal MS-DRG rate; and
- An increase in the cost outlier threshold from $21,748 to $24,626.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 0.6% decrease in payments for hospitals in large urban areas (populations over one million). Using the impact percentages in the Final IPPS Rule as applied to our IPPS payments for the 12 months ended September 30, 2014, the estimated annual impact for all changes in the Final IPPS Rule on our hospitals is a decrease in our Medicare inpatient revenues of approximately $13 million, most of which is related to an expected decrease in UC-DSH reimbursement. Because of the uncertainty regarding 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 September 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 12 months ended September 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 September 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 12 months ended September 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, as well as the related effects of compliance with admission criteria, we cannot provide any assurances regarding our estimate of the impact of these changes.

Payment and Policy Changes to the Medicare Outpatient Prospective Payment System

On October 31, 2014, CMS released the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems changes for calendar year 2015 ("OPPS Final Rule"). The OPPS Final Rule includes the following payment and policy changes:

- An estimated market basket increase of 2.9%, minus market basket index and multifactor productivity reductions required by the ACA of 0.2% and 0.5%, 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 OPPS Final Rule will yield an average 2.3% increase in OPPS payments for all hospitals and an average 2.5% 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 OPPS Final Rule on our hospitals is a $13 million increase in Medicare outpatient revenues. Because of the uncertainty associated with 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.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On October 31, 2014, CMS released the 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 Congress intervenes. In March 2014 (prior to the enactment of the PAMA), CMS estimated that the MPFS SGR-based update for calendar year 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 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.

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 nine months ended September 30, 2014 and 2013 was $6.8 billion and $4.1 billion, respectively. Approximately 62% of our managed care net patient revenues for the nine months ended September 30, 2014 was derived from our top ten managed care payers. National payers generated approximately 46% of our total net managed care revenues. The remainder comes from regional or local payers. At September 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 September 30, 2014, a 3% increase or decrease in the estimated contractual allowances 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 experienced improved year-over-year managed care pricing, we expect some moderation in the pricing percentage increases in future years. In the nine months ended September 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 high unemployment rates in some of the markets our hospitals serve, 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 September 30, 2014 and December 31, 2013, approximately 6% 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 the operations of Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC. 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 September 30, 2014 and 2013 were approximately $135 million and $116 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $488 million and $342 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, Resolute Health Hospital and Emanuel Medical Center.) 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 September 30, 2014 and 2013 were approximately $178 million and $72 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $493 million and $257 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 September 30, 2014 and 2013 were approximately $42 million and $32 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $137 million and $95 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 has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, even with the implementation of the ACA, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage under the ACA and for persons living in the country without legal permission who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

Table of Contents

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 nine months ended September 30, 2014 and 2013:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues:				
General hospitals	$ 3,912	$ 2,361	$ 11,576	$ 7,135
Other operations	516	257	1,520	706
Net operating revenues before provision for doubtful accounts	4,428	2,618	13,096	7,841
Less provision for doubtful accounts	249	210	949	624
Net operating revenues	**4,179**	**2,408**	**12,147**	**7,217**
Operating expenses:				
Salaries, wages and benefits	2,028	1,172	5,905	3,499
Supplies	665	387	1,942	1,158
Other operating expenses, net	1,032	575	3,066	1,710
Electronic health record incentives	(5)	(14)	(72)	(48)
Depreciation and amortization	207	119	609	354
Impairment and restructuring charges, and acquisition-related costs	37	20	90	45
Litigation and investigation costs	4	1	19	3
Operating income	**$ 211**	**$ 148**	**$ 588**	**$ 496**

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	100.0 %	100.0 %	100.0 %	100.0 %
Operating expenses:				
Salaries, wages and benefits	48.5 %	48.7 %	48.6 %	48.5 %
Supplies	15.9 %	16.1 %	16.0 %	16.0 %
Other operating expenses, net	24.7 %	24.0 %	25.3 %	23.8 %
Electronic health record incentives	(0.1)%	(0.6)%	(0.6)%	(0.7)%
Depreciation and amortization	5.0 %	4.9 %	5.0 %	4.9 %
Impairment and restructuring charges, and acquisition-related costs	0.9 %	0.8 %	0.7 %	0.6 %
Litigation and investigation costs	0.1 %	— %	0.2 %	— %
Operating income	**5.0 %**	**6.1 %**	**4.8 %**	**6.9 %**

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 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 September 30, 2014 and 2013, respectively, and approximately 88% and 91% for the nine months ended September 30, 2014 and 2013, respectively.

Net operating revenues from our other operations were $516 million and $257 million in the three months ended September 30, 2014 and 2013, respectively, and $1.520 billion and $706 million in the nine months ended September 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 health plans acquired from Vanguard 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 September 30, 2014 and 2013, respectively, and $9 million and $13 million in the nine months ended September 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, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014, in each case only for the period of time from such acquisition or opening to September 30, 2014. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase in the scale of our operations as a result of these investments.

	Total Hospital Continuing Operations					
	Three Months Ended September 30,			Nine Months Ended September 30,		
	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total admissions	199,914	121,569	64.4 %	588,828	368,220	59.9 %
Adjusted patient admissions[1]	345,787	196,761	75.7 %	1,007,106	589,866	70.7 %
Paying admissions (excludes charity and uninsured)	188,924	112,760	67.5 %	554,381	341,977	62.1 %
Charity and uninsured admissions	10,990	8,809	24.8 %	34,447	26,243	31.3 %
Admissions through emergency department	123,147	75,512	63.1 %	367,834	231,328	59.0 %
Emergency department visits	719,835	400,345	79.8 %	2,086,846	1,202,125	73.6 %
Total emergency department admissions and visits	842,982	475,857	77.2 %	2,454,680	1,433,453	71.2 %
Surgeries — inpatient	55,339	34,971	58.2 %	160,186	102,515	56.3 %
Surgeries — outpatient	123,100	76,084	61.8 %	354,199	218,622	62.0 %
Total surgeries	178,439	111,055	60.7 %	514,385	321,137	60.2 %
Patient days — total	921,228	569,833	61.7 %	2,757,485	1,740,508	58.4 %
Adjusted patient days[1]	1,574,346	912,483	72.5 %	4,663,406	2,762,043	68.8 %
Average length of stay (days)	4.61	4.69	(1.7)%	4.68	4.73	(1.1)%
Average licensed beds	20,692	13,180	57.0 %	20,439	13,180	55.1 %
Utilization of licensed beds[2]	48.4 %	47.0 %	1.4 %[3]	49.4 %	48.4 %	1.0 %[3]
Total visits	2,125,002	1,071,421	98.3 %	6,138,740	3,198,922	91.9 %
Paying visits (excludes charity and uninsured)	1,954,980	956,871	104.3 %	5,633,704	2,859,799	97.0 %
Charity and uninsured visits	170,022	114,550	48.4 %	505,036	339,123	48.9 %
Net inpatient revenues	$ 2,463	$ 1,502	64.0 %	$ 7,296	$ 4,580	59.3 %
Net outpatient revenues	$ 1,441	$ 845	70.5 %	$ 4,235	$ 2,502	69.3 %
Net inpatient revenue per admission	$ 12,320	$ 12,355	(0.3)%	$ 12,391	$ 12,438	(0.4)%
Net inpatient revenue per patient day	$ 2,674	$ 2,636	1.4 %	$ 2,646	$ 2,631	0.6 %
Net outpatient revenue per visit	$ 678	$ 789	(14.1)%	$ 690	$ 782	(11.8)%
Net patient revenue per adjusted patient admission[1]	$ 11,290	$ 11,928	(5.3)%	$ 11,450	$ 12,006	(4.6)%
Net patient revenue per adjusted patient day[1]	$ 2,480	$ 2,572	(3.6)%	$ 2,473	$ 2,564	(3.5)%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(2) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

(3) The change is the difference between the 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, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014.

	Same-Hospital Continuing Operations					
	Three Months Ended September 30,			Nine Months Ended September 30,		
Admissions, Patient Days and Surgeries	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total admissions	127,118	121,569	4.6 %	376,289	368,220	2.2 %
Adjusted patient admissions[1]	208,229	196,761	5.8 %	609,721	589,866	3.4 %
Paying admissions (excludes charity and uninsured)	118,580	112,760	5.2 %	351,445	341,977	2.8 %
Charity and uninsured admissions	8,538	8,809	(3.1)%	24,844	26,243	(5.3)%
Admissions through emergency department	80,328	75,512	6.4 %	241,767	231,328	4.5 %
Paying admissions as a percentage of total admissions	93.3 %	92.8 %	0.5 %[2]	93.4 %	92.9 %	0.5 %[2]
Charity and uninsured admissions as a percentage of total admissions	6.7 %	7.2 %	(0.5)%[2]	6.6 %	7.1 %	(0.5)%[2]
Emergency department admissions as a percentage of total admissions	63.2 %	62.1 %	1.1 %[2]	64.3 %	62.8 %	1.5 %[2]
Surgeries — inpatient	35,570	34,971	1.7 %	103,468	102,515	0.9 %
Surgeries — outpatient	91,472	76,084	20.2 %	262,460	218,622	20.1 %
Total surgeries	127,042	111,055	14.4 %	365,928	321,137	13.9 %
Patient days — total	594,664	569,833	4.4 %	1,783,957	1,740,508	2.5 %
Adjusted patient days[1]	962,054	912,483	5.4 %	2,859,601	2,762,043	3.5 %
Average length of stay (days)	4.68	4.69	(0.2)%	4.74	4.73	0.2 %
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	13,231	13,180	0.4 %	13,202	13,180	0.2 %
Utilization of licensed beds[3]	48.9 %	47.0 %	1.9 %[2]	49.5 %	48.4 %	1.1 %[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 September 30,			Nine Months Ended September 30,		
Outpatient Visits	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total visits	1,155,852	1,071,421	7.9 %	3,377,121	3,198,922	5.6 %
Paying visits (excludes charity and uninsured)	1,042,636	956,871	9.0 %	3,043,373	2,859,799	6.4 %
Charity and uninsured visits	113,216	114,550	(1.2)%	333,748	339,123	(1.6)%
Emergency department visits	433,174	400,345	8.2 %	1,280,225	1,202,125	6.5 %
Surgery visits	91,472	76,084	20.2 %	262,460	218,622	20.1 %
Paying visits as a percentage of total visits	90.2 %	89.3 %	0.9 %[1]	90.1 %	89.4 %	0.7 %[1]
Charity and uninsured visits as a percentage of total visits	9.8 %	10.7 %	(0.9)%[1]	9.9 %	10.6 %	(0.7)%[1]

(1) The change is the difference between 2014 and 2013 amounts shown.

	Same-Hospital Continuing Operations					
	Three Months Ended September 30,			Nine Months Ended September 30,		
Revenues	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Net operating revenues	$ 2,684	$ 2,408	11.5 %	$ 7,775	$ 7,217	7.7 %
Revenues from the uninsured	$ 150	$ 167	(10.2)%	$ 467	$ 502	(7.0)%
Net inpatient revenues[1]	$ 1,602	$ 1,502	6.7 %	$ 4,711	$ 4,580	2.9 %
Net outpatient revenues[1]	$ 924	$ 845	9.3 %	$ 2,710	$ 2,502	8.3 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $56 million and $68 million for the three months ended September 30, 2014 and 2013, respectively, and $181 million and $207 million for the nine months ended September 30, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $94 million and $99 million for the three months ended September 30, 2014 and 2013, respectively, and $286 million and $295 million for the nine months ended September 30, 2014 and 2013, respectively.

	Same-Hospital Continuing Operations					
	Three Months Ended September 30,			Nine Months Ended September 30,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 12,602	$ 12,355	2.0 %	$ 12,520	$ 12,438	0.7 %
Net inpatient revenue per patient day	$ 2,694	$ 2,636	2.2 %	$ 2,641	$ 2,631	0.4 %
Net outpatient revenue per visit	$ 799	$ 789	1.3 %	$ 802	$ 782	2.6 %
Net patient revenue per adjusted patient admission[1]	$ 12,131	$ 11,928	1.7 %	$ 12,171	$ 12,006	1.4 %
Net patient revenue per adjusted patient day[1]	$ 2,626	$ 2,572	2.1 %	$ 2,595	$ 2,564	1.2 %

(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.

	Same-Hospital Continuing Operations					
	Three Months Ended September 30,			Nine Months Ended September 30,		
Provision for Doubtful Accounts	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Provision for doubtful accounts	$ 163	$ 210	(22.4)%	$ 602	$ 624	(3.5)%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	5.7 %	8.0 %	(2.3)%[1]	7.2 %	8.0 %	(0.8)%[1]
Collection rate on self-pay accounts[2]	27.5 %	28.8 %	(1.3)%[1]	27.5 %	28.8 %	(1.3)%[1]
Collection rate on commercial managed care accounts	98.3 %	98.3 %	— %[1]	98.3 %	98.3 %	— %[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.

	Same-Hospital Continuing Operations					
	Three Months Ended September 30,			Nine Months Ended September 30,		
Selected Operating Expenses	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Hospital Operations and other						
Salaries, wages and benefits	$ 1,150	$ 1,032	11.4 %	$ 3,330	$ 3,092	7.7 %
Supplies	416	387	7.5 %	1,232	1,158	6.4 %
Other operating expenses	587	526	11.6 %	1,740	1,558	11.7 %
Total	$ 2,153	$ 1,945	10.7 %	$ 6,302	$ 5,808	8.5 %
Conifer						
Salaries, wages and benefits	$ 182	$ 140	30.0 %	$ 531	$ 407	30.5 %
Other operating expenses	67	49	36.7 %	196	152	28.9 %
Total	$ 249	$ 189	31.7 %	$ 727	$ 559	30.1 %
Total						
Salaries, wages and benefits	$ 1,332	$ 1,172	13.7 %	$ 3,861	$ 3,499	10.3 %
Supplies	416	387	7.5 %	1,232	1,158	6.4 %
Other operating expenses	654	575	13.7 %	1,936	1,710	13.2 %
Total	$ 2,402	$ 2,134	12.6 %	$ 7,029	$ 6,367	10.4 %
Rent/lease expense[1]						
Hospital Operations and other	$ 37	$ 41	(9.8)%	$ 105	$ 118	(11.0)%
Conifer	5	3	66.7 %	16	10	60.0 %
Total	$ 42	$ 44	(4.5)%	$ 121	$ 128	(5.5)%
Hospital Operations and other[2]						
Salaries, wages and benefits per adjusted patient day	$ 1,193	$ 1,130	5.6 %	$ 1,162	$ 1,119	3.8 %
Supplies per adjusted patient day	432	424	1.9 %	431	419	2.9 %
Other operating expenses per adjusted patient day	593	565	5.0 %	591	561	5.3 %
Total per adjusted patient day	$ 2,218	$ 2,119	4.7 %	$ 2,184	$ 2,099	4.0 %
Salaries, wages and benefits per adjusted patient admission	$ 5,513	$ 5,240	5.2 %	$ 5,452	$ 5,240	4.0 %
Supplies per adjusted patient admission	1,998	1,967	1.6 %	2,021	1,963	3.0 %
Other operating expenses per adjusted patient admission	2,737	2,622	4.4 %	2,769	2,625	5.5 %
Total per adjusted patient admission	$ 10,248	$ 9,829	4.3 %	$ 10,242	$ 9,828	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 SEPTEMBER 30, 2014 COMPARED TO THREE MONTHS ENDED SEPTEMBER 30, 2013

Revenues

During the three months ended September 30, 2014, same-hospital net operating revenues increased 11.5% compared to the three months ended September 30, 2013, primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts, and increased revenues from services provided by our Conifer subsidiary to third parties.

Our same-hospital net outpatient revenues and total outpatient visits increased 9.3% and 7.9%, respectively, during the three months ended September 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 development program. Net outpatient revenue per visit increased 1.3% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $296 million and $225 million for the three months ended September 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 4.4% during the three months ended September 30, 2014 compared to the three months ended September 30, 2013. We believe our volumes were positively impacted by incremental market share we generated through 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 inpatient volume levels continue 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 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 5.7% for the three months ended September 30, 2014 compared to 8.0% for the three months ended September 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 and the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the 130 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 September 30, 2014 and December 31, 2013:

	September 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	$ 358	$ —	$ 358	$ 301	$ —	$ 301
Medicaid	153	—	153	133	—	133
Net cost report settlements payable and valuation allowances	(91)	—	(91)	(75)	—	(75)
Managed care	1,458	90	1,368	1,179	69	1,110
Self-pay uninsured	476	416	60	344	290	54
Self-pay balance after insurance	208	128	80	224	141	83
Estimated future recoveries from accounts assigned to our Conifer subsidiary	122	—	122	92	—	92
Other payers	324	138	186	278	89	189
Total continuing operations	3,008	772	2,236	2,476	589	1,887
Total discontinued operations	3	1	2	3	—	3
	$ 3,011	**$ 773**	**$2,238**	**$ 2,479**	**$ 589**	**$1,890**

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 September 30, 2014, our same-hospital collection rate on self-pay accounts was approximately 27.5%. 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; 28.1% at March 31, 2014; and 27.8% at June 30, 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 September 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 $10 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 September 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 $2.327 billion and $1.962 billion at September 30, 2014 and December 31, 2013, respectively, excluding cost report settlements payable and valuation allowances of $91 million and $75 million at September 30, 2014 and December 31, 2013, respectively:

	September 30, 2014				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	83 %	49 %	68 %	28 %	62 %
61-120 days	7 %	20 %	14 %	18 %	14 %
121-180 days	4 %	11 %	6 %	11 %	7 %
Over 180 days	6 %	20 %	12 %	43 %	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 49.3 days at September 30, 2014 and 44.7 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 September 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 $2.9 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 newly acquired facilities are beginning to implement this program. Based on recent trends, approximately 92% 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 September 30, 2014 and December 31, 2013 by aging category on a same-hospital basis:

	September 30, 2014	December 31, 2013
0-60 days	$ 85	$ 132
61-120 days	19	28
121-180 days	7	8
Over 180 days	17	18
Total	**$ 128**	**$ 186**

Salaries, Wages and Benefits

Salaries, wages and benefits expense as a percentage of net operating revenues decreased 0.2% for the three months ended September 30, 2014 compared to the three months ended September 30, 2013. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 5.2% in the three months ended September 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 September 30, 2014 and 2013 included stock-based compensation expense of $13 million and $7 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $42 million in the three months ended September 30, 2014 compared to the three months ended September 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 September 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 five expired contracts and are negotiating renewals under extension agreements. We are also negotiating first contracts at two 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.

Supplies

Supplies expense as a percentage of net operating revenues decreased 0.2% for the three months ended September 30, 2014 compared to the three months ended September 30, 2013. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 1.6% in the three months ended September 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 24.7% in the three months ended September 30, 2014 compared to 24.0% in the three months ended September 30, 2013. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 4.4% in the three months ended September 30, 2014 compared to the same period in 2013. The 11.6% increase in same-hospital other operating expenses in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 is due to:

- increased costs of contracted services ($13 million);
- increased costs associated with funding indigent care services by certain of our Texas hospitals ($13 million) which were substantially offset by additional net patient revenues;
- higher medical fees primarily related to a greater number of employed and contracted physicians ($8 million); and
- increased malpractice expense ($11 million).

Malpractice expense in the three months ended September 30, 2014 included a favorable adjustment of approximately $1 million due to a nine basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to favorable adjustment of approximately $2 million as a result of a six basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $18 million in the three months ended September 30, 2014 compared to the three months ended September 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 September 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $37 million, consisting of $5 million of employee severance costs, $6 million of contract and lease termination fees, $1 million of restructuring costs, and $25 million in acquisition-related costs, which include $3 million of transaction costs and $22 million of acquisition integration charges.

During the three months ended September 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $20 million, consisting of $4 million of employee severance costs, $3 million of restructuring costs and $13 million in acquisition-related costs.

Litigation and Investigation Costs

Litigation and investigation costs for the three months ended September 30, 2014 and 2013 were $4 million and $1 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

Interest Expense

Interest expense for the three months ended September 30, 2014 was $186 million compared to $91 million for the three months ended September 30, 2013, primarily due to increased borrowings relating to our recent acquisitions.

Loss from Early Extinguishment of Debt

During the three months ended September 30, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9 1/4% senior notes due 2015 that we redeemed in 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 September 30, 2014, we recorded income tax benefit of $18 million compared to income tax expense of $16 million during the three months ended September 30, 2013. The benefit recorded in the 2014 period primarily related to the loss from early extinguishment of debt recognized in that period and the impact of income tax benefit related to tax basis adjustments for state tax purposes on our acquisition of Vanguard.

NINE MONTHS ENDED SEPTEMBER 30, 2014 COMPARED TO NINE MONTHS ENDED SEPTEMBER 30, 2013

Revenues

During the nine months ended September 30, 2014, same-hospital net operating revenues after provision for doubtful accounts increased 7.7% compared to the nine months ended September 30, 2013, primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts and an increase in our other operations revenues.

Our same-hospital net outpatient revenues and total outpatient visits increased 8.3% and 5.6%, respectively, during the nine months ended September 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 development program. Net outpatient revenue per visit increased 2.6% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $866 million and $655 million for the nine months ended September 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 2.5% during the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. We believe our volumes were positively impacted by incremental market share we generated through 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 inpatient volume levels continue 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 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 7.2% and 8.0% for the nine months ended September 30, 2014 and 2013, respectively. 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 and the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the 130 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 0.1% for the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 4.0% in the nine months ended September 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 nine months ended September 30, 2014 and 2013 included stock-based compensation expense of $38 million and $27 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $124 million in the nine months ended September 30, 2014 compared to the nine months ended September 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 nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 3.0% in the nine months ended September 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 25.3% in the nine months ended September 30, 2014 compared to 23.8% in the nine months ended September 30, 2013. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 5.5% in the nine months ended September 30, 2014 compared to the same period in 2013. The 11.7% increase in same-hospital other operating expenses in the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013 is due to:

- increased costs of contracted services ($28 million);
- higher medical fees primarily related to a greater number of employed and contracted physicians ($44 million);
- increased costs associated with funding indigent care services by certain of our Texas hospitals ($18 million), which were substantially offset by additional net patient revenues;
- increased malpractice expense ($48 million); and
- decreased rent and lease expense ($13 million).

Malpractice expense in the nine months ended September 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 23 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 $8 million as a result of an 84 basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $44 million in the nine months ended September 30, 2014 compared to the nine months ended September 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 nine months ended September 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $90 million, consisting of $14 million of employee severance costs, $6 million of contract and lease termination fees, $19 million of restructuring costs, and $51 million in acquisition-related costs, which include $7 million of transaction costs and $44 million of acquisition integration charges.

During the nine months ended September 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $45 million, consisting of $2 million relating to the impairment of property, $10 million of restructuring costs, $9 million of employee severance costs, $1 million in lease termination costs, and $23 million in acquisition-related costs.

Litigation and Investigation Costs

Litigation and investigation costs for the nine months ended September 30, 2014 and 2013 were $19 million and $3 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

Interest Expense

Interest expense for the nine months ended September 30, 2014 was $558 million compared to $292 million for the nine months ended September 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 nine months ended September 30, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9 1/4% senior notes due 2015 that we redeemed in the period, as well as the write-off of associated unamortized note discounts and issuance costs.

During the nine months ended September 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 nine months ended September 30, 2014, we recorded income tax benefit of $11 million compared to $57 million during the nine months ended September 30, 2013. The benefit recorded in the 2014 period related primarily to the loss from early extinguishment of debt recognized in that period and the impact of income tax benefit related to tax basis adjustments for state tax purposes on our acquisition of Vanguard. The benefit recorded in the 2013 period primarily related to the loss from early extinguishment of debt recognized in that period.

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 nine months ended September 30, 2014 and 2013:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ 9	$ 28	$ (49)	$ (110)
Less: Net (income) attributable to noncontrolling interests	(9)	(8)	(44)	(20)
Loss from discontinued operations, net of tax	(1)	(5)	(22)	(4)
Income (loss) from continuing operations	19	41	17	(86)
Income tax benefit (expense)	18	(16)	11	57
Investment earnings	—	—	—	1
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Interest expense	(186)	(91)	(558)	(292)
Operating income	211	148	588	496
Litigation and investigation costs	(4)	(1)	(19)	(3)
Impairment and restructuring charges, and acquisition-related costs	(37)	(20)	(90)	(45)
Depreciation and amortization	(207)	(119)	(609)	(354)
Adjusted EBITDA	**$ 459**	**$ 288**	**$ 1,306**	**$ 898**
Net operating revenues	**$ 4,179**	**$ 2,408**	**$ 12,147**	**$ 7,217**
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	**11.0 %**	**12.0 %**	**10.8 %**	**12.4 %**

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 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 September 30, 2014, using the last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 6.5x. 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 and the Risk Factors section in Part II of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and

replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements. Capital expenditures were $734 million and $398 million in the nine months ended September 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.

During the nine months ended September 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, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. We also acquired four 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 $185 million.

Interest payments, net of capitalized interest, were $487 million and $295 million in the nine months ended September 30, 2014 and 2013, respectively.

Income tax payments, net of tax refunds, were approximately $5 million in each of the nine month periods ended September 30, 2014 and 2013.

SOURCES AND USES OF CASH

Our liquidity for the nine months ended September 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 $200 million of cash and cash equivalents on hand at September 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 September 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 $468 million in the nine months ended September 30, 2014 compared to $334 million in the nine months ended September 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 $408 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 nine months ended September 30, 2014 compared to the nine months ended September 30, 2013;
- $11 million more cash used in operating activities from discontinued operations;
- An increase of $79 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- Higher interest payments of $192 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 underutilized or inefficient assets.

Capital expenditures were $734 million and $398 million in the nine months ended September 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 September 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 September 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 September 30, 2014, we had approximately $115 million of standby letters of credit outstanding under the LC Facility.

In September 2014, we sold $500 million aggregate principal amount of $5^1/_2$% 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 March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

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, which payments commenced 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 net 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 and acquisitions, 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, equity offerings, 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 and development 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.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the nine months ended September 30, 2014 and 2013 include $345 million and $715 million, respectively, of net operating revenues and $53 million and $93 million, respectively, of operating income generated from general hospitals operated by us under operating lease arrangements (two hospitals as of September 30, 2014 and four hospitals as of September 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 $248 million of standby letters of credit outstanding and guarantees as of September 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 September 30, 2014. The fair values were determined based on quoted market prices for the same or similar instruments.

Table of Contents

The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2014	2015	2016	2017	2018	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 46	$ 87	$ 45	$ 58	$ 1,051	$ 10,287	$ 11,574	$ 11,997
Average effective interest rates	7.0 %	6.3 %	6.5 %	8.5 %	6.6 %	6.7 %	6.7 %	

At September 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 September 30, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Table of Contents

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 ("Annual Report"), 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. The CFPB has recently indicated that it currently expects to communicate its conclusions regarding the investigation sometime in the fourth quarter of 2014. If the CFPB determines that a violation of the federal consumer financial laws has occurred, it has the authority to impose fines, require operational changes or take other corrective actions. At this time, because we have not yet met with the CFPB nor has the agency communicated its conclusions regarding the investigation to us, we are unable to predict the outcome of the investigation or provide an estimate of possible range of loss.

ITEM 1A. RISK FACTORS

There have been no material changes to the risk factors discussed in our Annual Report except as set forth below.

Our business and financial results could be harmed by a national or localized outbreak of a highly contagious or epidemic disease.

If an outbreak of an infectious disease such as the Ebola virus were to occur nationally or in one of the regions our hospitals serve, our business and financial results could be adversely effected. The treatment of a highly contagious disease at one of our facilities may result in a temporary shutdown or diversion of patients. In addition, unaffected individuals may decide to defer elective procedures or otherwise avoid medical treatment, resulting in reduced patient volumes and operating revenues. Furthermore, we cannot predict the costs associated with the potential treatment of an infectious disease outbreak by our hospitals or preparation for such treatment.

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Table of Contents

ITEM 6. EXHIBITS

(4) Instruments Defining the Rights of Security Holders, Including Indentures

(a) Twenty-Fourth Supplemental Indenture, dated as of September 29, 2014, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to $5^{1}/_{2}$% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K dated and filed September 29, 2014)

(10) Material Contracts

(a) Exchange and Registration Rights Agreement, dated as of September 29, 2014, between the Registrant and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as representative of the initial purchasers (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated and filed September 29, 2014)

(31) Rule 13a-14(a)/15d-14(a) Certifications

(a) Certification of Trevor Fetter, President and Chief Executive Officer

(b) Certification of Daniel J. Cancelmi, Chief Financial Officer

(32) Section 1350 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

Table of Contents

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: November 3, 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: November 3, 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: November 3, 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 September 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: November 3, 2014

/s/ TREVOR FETTER
Trevor Fetter
President and Chief Executive Officer

Date: November 3, 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.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 14: MAIN STREET CERTIFICATE OF INCORPORATION

000813

CERTIFICATE OF INCORPORATION
NONSTOCK CORPORATION

61-27 REV. 12/88

STATE OF CONNECTICUT
SECRETARY OF THE STATE
30 Trinity Street, Hartford, CT 06106

The undersigned incorporator(s) hereby form(s) a corporation under the Nonstock Corporation Act of the State of Connecticut:

1. **The name of the corporation is** MAIN STREET COMMUNITY FOUNDATION, INC.

2. **The nature of the activities to be conducted, or the purposes to be promoted or carried out by the corporation, are as follows:**

   See Attached

3. **The corporation is nonprofit and shall not have or issue shares of stock or pay dividends.**

4. **The classes, rights, privileges, qualifications, obligations, and the manner of election or appointment of members are as follows: (If the corporation is to have no members, or only members not entitled to vote, so state).**

   The Corporation is to have no members.

5. **Other provisions:** See Attached.

Dated at Bristol, Connecticut this 17th day of March 19 95

I/We hereby declare, under the penalties of false statement, that the statements made in the foregoing certificate are true.

This certificate of incorporation must be signed by each incorporator.

NAME OF INCORPORATOR *(Print/Type)*	NAME OF INCORPORATOR *(Print/Type)*	NAME OF INCORPORATOR *(Print/Type)*
1. Sherwood L. Anderson	2. Edward P. Lorenson	3. Robert S. Merriman
SIGNED *(Incorporator)* 1.	SIGNED *(Incorporator)* 2.	SIGNED *(Incorporator)* 3.

FOR OFFICE USE ONLY

Rec; CC; G.S:

(Please provide ... g receipt)

RETURN TO:
ANDERSON ALDEN
HAYES & ZIOGAS
238 MAIN STREET
P. O. Box 1197
BRISTOL, CT 06011-1197

(0875/17)

NAME OF INCORPORATOR (Print/Type)	NAME OF INCORPORATOR (Print/Type)
4 . David J. Preleski	5 . Christopher Ziogas
SIGNED (Incorporator) 4.	SIGNED (Incorporator) 5.

NAME OF INCORPORATOR (Print/Type)	NAME OF INCORPORATOR (Print/Type)
6. John E. Smith	7 . Carlyle F. Barnes
SIGNED (Incorporator) 6.	SIGNED (Incorporator) 7.

NAME OF INCORPORATOR (Print/Type)	SIGNED (Incorporator)
5.	5.

MAIN STREET COMMUNITY FOUNDATION, INC.

CERTIFICATE OF INCORPORATION

2. (a) To accept, hold, invest, reinvest, and administer any gifts, bequests, devises, benefits of trusts, and property of any sort, without limitation as to amount or value, and to use, disburse, or donate the income or principal thereof for exclusively charitable purposes; in central and north central Connecticut.

(b) To give, convey, or assign any of its property outright, or upon lawful terms regarding the use thereof, to other organizations, provided that: (1) such organizations shall be organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals; (2) transfers of property to such organizations shall, to the extent then permitted under the statutes of the United States Government, be exempt from gift, succession, inheritance, estate, or death taxes (by whatever name called) imposed by the United States Government; and (3) such organizations shall, to the extent then permitted under the statutes of the United States Government, be exempt from income taxes imposed by the United States Government.

(c) Alone or in cooperation with other persons or organizations, to do any and all lawful acts and things which may be necessary, useful, suitable, or proper for the furtherance, accomplishments, or attainment of any or all of the purposes or powers of the Corporation.

(d) To conduct the activities and all lawful acts of a Community Foundation under Connecticut law and the provisions of the U.S. Internal Revenue Code.

5. The Corporation shall pay no funds to any private individuals except for compensation for services actually rendered to the Corporation, or for reimbursement of expenses actually incurred by such individual on behalf of the Corporation. Directors, committee members, and officers (except for staff) must serve without compensation of any kind, except for reimbursement of out of pocket expenses incurred on behalf of the Corporation. Upon the dissolution of the Corporation, assets shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of

shall be disposed of by the Superior Court of the county in which the principal office of the corporation is then located, exclusively for such purposes or to such organizations or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

6. (a) No part of the net earnings of the Corporation shall inure to the benefit of the director, officer of the Corporation, or any private individual (except that reasonable compensation may be paid for services rendered to or for the Corporation carrying out one or more of its purposes), and no director, officer of the Corporation, or any private individual shall be entitled to share in the distribution of any of the corporate assets on dissolution of the Corporation. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting, to influence legislation, and the Corporation shall not participate in or intervene in (including the publication or distribution of statements) any political campaign on behalf of any candidate for public office.

(b) The Corporation shall distribute its income for each taxable year at such time and in such manner as not to become subject to the tax on undistributed income imposed by Section 4942 of the Internal Revenue Code of 1954, or corresponding provisions of any subsequent federal tax laws.

(c) The Corporation shall not engage in any act of self-dealing as defined in Section 4941(d) of the Internal Revenue Code of 1954, or corresponding provisions of any subsequent federal tax laws.

(d) The Corporation shall not retain any excess business holdings as defined in Section 4943(c) of the Internal Revenue Code of 1954, or corresponding provisions of any subsequent federal tax laws.

(e) The Corporation shall not make any investments in such manner as to subject it to tax under Section 4944 of the Internal Revenue Code of 1954, or corresponding provisions of any subsequent federal tax laws.

(f) The Corporation shall not make any taxable expenditures as defined in Section 4945(d) of the Internal Revenue Code of 1954, or corresponding provisions of any subsequent federal tax laws.

(g) The Corporation shall at all times conform to the provisions of the Internal Revenue Code of 1954 with regard to the qualification for tax exemption of community foundations, or corresponding provisions of any subsequent federal tax laws.

(h) Notwithstanding any other provision of this certificate, the Corporation shall not carry on any activities not permitted by an organization exempt under Section 501(c)(3) of the Internal Revenue Code and its Regulations as they now exist or as they may be amended, or by an organization, contributions to which are deductible under Section 170(c)(2) of the Code and Regulations as they now exist or as they may be amended.

7. (a) The Corporation shall indemnify, to the fullest extent permitted under the laws of the State of Connecticut, all officers, directors, committee members, employees and agents of the Corporation, including but not limited to, the indemnification and other provisions set forth in Section 33-454a of the Connecticut General Statutes as amended.

(b) Directors shall not be liable to the Corporation or to third parties; except as provided in Section 33-455 of the Connecticut General Statutes and as otherwise provided by law.

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 15: MAIN STREET IRS DETERMINATION LETTER

IRS Department of the Treasury
Internal Revenue Service
P.O. Box 2508
Cincinnati OH 45201

In reply refer to: 0248452924
Oct. 24, 2008 LTR 4168C E0
06-1433299 000000 00 000
00016461
BODC: TE

MAIN STREET COMMUNITY FOUNDATION
PO BOX 2702
BRISTOL CT 06011-2702029

015456

Employer Identification Number: 06-1433299
Person to Contact: Maggie Webster
Toll Free Telephone Number: 1-877-829-5500

Dear Taxpayer:

This is in response to your request of Oct. 15, 2008, regarding your tax-exempt status.

Our records indicate that a determination letter was issued in January 1996, that recognized you as exempt from Federal income tax, and discloses that you are currently exempt under section 501(c)(3) of the Internal Revenue Code.

Our records also indicate you are not a private foundation within the meaning of section 509(a) of the Code because you are described in section(s) 509(a)(1) and 170(b)(1)(A)(vi).

Donors may deduct contributions to you as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely yours,

Michele M. Sullivan

Michele M. Sullivan, Oper. Mgr.
Accounts Management Operations I

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 16: MAIN STREET BYLAWS

AMENDED AND RESTATED BY-LAWS

OF

MAIN STREET COMMUNITY FOUNDATION, INC.

EFFECTIVE AS OF JUNE 8, 2012

ARTICLE I

NAME

Section 1. Name. The name of this Corporation is MAIN STREET COMMUNITY FOUNDATION, INC.

ARTICLE II

SPECIFIC PURPOSES OF THE CORPORATION

The specific purposes for which this Corporation was organized are fully set forth in the Certificate of Incorporation. Such purposes, in brief, are to organize and operate a community foundation and to receive and administer funds for religious, charitable, scientific, literary, or education purposes, or for the prevention of cruelty to children or animals, all for the public welfare, and for no other purposes.

ARTICLE III

GOVERNMENT

Section 1. General Powers. The Corporation shall not have members. The control and management of the Corporation and its properties shall be vested in a Board of Directors. In addition to the powers and authority by the By-Laws and the Certificate of Incorporation expressly conferred upon them, the Board may exercise all such powers of the Corporation and do all such lawful acts and things as are not by statute or by the Certificate of Incorporation or by these By-Laws prohibited.

Section 2. Number. The Board of Directors shall be comprised of not less than twelve (12) and not more than fifteen (15) persons who shall serve for a three (3) year term or until their successors are duly nominated, elected and qualified. The terms of the above directors shall be staggered such that approximately one-third of the Directors shall have terms that terminate at each Annual Meeting. In addition, the Officers set forth in Article V, Section 1, shall be members of the Board of Directors during their term of office.

Section 3. Tenure. The Directors named by the incorporators of the Corporation shall

have the control and management of the Corporation until the next Annual Meeting of the Directors. At the next and each subsequent Annual Meeting of Directors, the Directors (including those whose terms are expiring) shall determine the total number of Directors who shall constitute the Board for the ensuing year, and then elect sufficient Directors for three (3) year terms to fill all places available. No Director shall be eligible to serve for more than two (2) consecutive full three (3) year terms, except that all Officers shall nevertheless serve as Directors during their terms of office.

Section 4. Duties and Obligations: Directors shall attend at least seventy-five (75%) percent of the meetings of the Board of Directors, participate on committees, be ambassadors of the Foundation in the community and perform such other duties as designated by the Board of Directors.

Section 5. Resignation and Removal: Any director elected or appointed by the Board of Directors may be removed at any time by the affirmative vote of two-thirds of the whole Board of Directors.

Section 6 Vacancies. All vacancies in the Board of Directors, whether caused by resignation, death or otherwise, may be filled by the Board of Directors at any regular or Special meeting. A Director thus elected to fill any vacancy shall hold office until the next Annual Meeting of Directors and until a successor is nominated, elected and qualified.

Section 7 Compensation. Directors, committee members, and officers (except for staff) shall serve without compensation of any kind, except for out of pocket expenses incurred on behalf of the Corporation.

Section 8 Founders. The following persons who were instrumental in the formation of the Corporation and thereby provided exemplary and extraordinary services to the Corporation shall be designated Founders: Sherwood Anderson, Carlyle Barnes, Thomas Barnes, Delores Capers, Ann Clark, Terry Fletcher, Edward Lorenson, Robert Merriman, David Preleski, Jeanne Radcliff, John Smith, Gary Weed and Christopher Ziogas. Founders shall be entitled to be present and participate in meetings of the Board of Directors, unless barred by the Corporation's conflict of interest policies, but shall not have voting privileges.

ARTICLE IV

MEETINGS OF THE BOARD OF DIRECTORS

Section 1. Annual Meeting. The Board of Directors shall hold its Annual Meeting each year upon seven (7) days written notice in the month of January or February as determined by the Chairman of the Board or as determined by the Board of Directors.

Section 2. Regular Meetings. Regular meetings of the Directors shall be held without notice at the offices of the Corporation, in any City in the State of Connecticut, or at such place

outside the State of Connecticut as the Directors may from time to time designate. There shall be a minimum of six (6) regular meetings of the Board of Directors during the calendar year.

Section 3. Special Meetings. Special meetings of the Board of Directors may be called at any time by the Chairman of the Board, or in his or her absence by any Vice-Chairman, or by the President, or upon the call of any two (2) Directors, to be held at the office of the Corporation or at such other place or places as the Directors may from time to time designate.

Section 4. Notice. Notice of Special meetings of the Board shall be given to each Director by at least three (3) calendar days notification of the same by letter, telephone, facsimile, e-mail or in person, but Special Meetings may be held with less than three (3) calendar days notification if all Directors waive such notice or are in attendance at such meeting.

Section 5. Quorum. A majority of the whole Board of Directors shall be necessary at all meetings to constitute a quorum for the transaction of business; but less than a quorum may adjourn the meeting which may be held on a subsequent date without further notice, provided a quorum be present at such deferred meeting. Unless otherwise specifically provided by statute, the act of majority of the Directors present at any properly convened meeting at which there is a quorum shall be the act of the Board. A Director shall be considered present at a meeting if the Director participates by telephone to consider the business at hand.

Section 6. Voting. Each Director shall be entitled to cast one vote on each matter submitted to a vote at any meeting of the Board of Directors. Director voting by proxy shall not be permitted.

ARTICLE V

OFFICERS

Section 1. Number and Designation. The officers of the Corporation shall be a Chairman of the Board, one or more Vice-Chairmen, a President, a Secretary and a Treasurer, and the Immediate Past Chairman.

Section 2. Appointment, Term of Office and Qualification. The Chairman of the Board, Vice Chairmen, Secretary and Treasurer shall be elected for a term of two (2) years by the Board of Directors at every second Annual Meeting and shall serve until their successors shall be duly nominated, elected and qualified. An officer shall not succeed himself or herself in office. The President shall be a member of the Board of Directors.

Section 3. Vacancies. In the case of absence or inability to act of any officer of the Corporation and of any person herein authorized to act in his place, the Board of Directors may from time to time delegate the powers or duties of such officer to any other officer or any Director or other person whom it may select. Vacancies in any office arising from any cause

may be filled by the Directors at any regular, Special or Annual meeting, but such officers term shall expire at the next following Annual Meeting, and until such officers successor is nominated, qualified, and elected.

Section 4. Other Officers. The Board of Directors may appoint such other officers and agents as it shall deem necessary or expedient, who shall hold their offices for such terms and shall exercise such powers and perform such duties as shall be determined from time to time by the Board of Directors.

Section 5. Resignation and Removal. Except as provided in Section 3, the officers of the Corporation shall hold office until their successors are chosen and qualify. Any officer elected or appointed by the Board of Directors may be removed at any time, with or without cause, by the affirmative vote of a majority of the whole Board of Directors.

Section 6. Bonds. The Board of Directors may, by resolution, require any and all of the officers to give bonds to the Corporation, with sufficient surety or sureties, conditioned for the faithful performance of the duties of their respective offices, and to comply with such other conditions as may from time to time be required by the Board of Directors.

ARTICLE VI

DUTIES OF THE OFFICERS

Section 1. Chairman. The Chairman of the Board shall preside at all meetings of the Directors and shall have general supervision of the affairs of the Corporation, shall sign or countersign all contracts and other instruments of the Corporation as authorized by the Board of Directors; shall make reports to the Board of Directors and members and perform all such duties as are incident to his or her office or are properly required of him or her by the Board of Directors.

Section 2. Vice-Chairman. During the absence or disability of the Chairman of the Board, the Vice-Chairman in the order designated by the Board of Directors, shall exercise all the functions of the Chairman. Each Vice-Chairman shall have such powers and discharge such duties as may be assigned to him or her from time to time by the Board of Directors.

Section 3. Secretary. The Secretary shall issue notices for all meetings except that notice for Special Meetings of the Directors called at the request of two (2) Directors as provided in Section 2 of Article IV of the By-Laws may be issued by such Directors, shall keep minutes of all meetings, shall have charge of the seal and the corporate books, and shall make such reports and perform such other duties as are incident to his or her office, or are properly required of him or her by the Board of Directors.

Section 4. Treasurer. The Treasurer shall have the custody of all moneys and securities of the Corporation and shall keep regular books of account. He or she shall disburse the funds of

the Corporation in payment of the just demands against the Corporation as may be ordered by the Board of Directors, taking proper vouchers for such disbursements, and shall render to the Board of Directors a financial report of the Foundation at the end of each fiscal year, covering operations during such fiscal year, and shall render to the Board, from time to time, as may be required of him or her, an account of all transactions as Treasurer and of the financial condition of the Corporation. The Treasurer shall perform all duties incident to the office, or that are properly required by the Board of Directors.

Section 5. President. The President shall be the Chief Executive Officer of the Corporation and shall have the general power of supervision and management of the Corporation as is usually vested in the chief executive officer of a corporation and shall see that all orders and resolutions of the Board of Directors are carried into effect. The President shall have the privilege of discussing all matters brought before the Board and shall have the same voting rights as any other Board director. The President may sign or countersign checks and other instruments as may require the President's signature and shall perform all duties incident to the office of President and those that are properly required of the President by the Board of Directors. The President shall serve at the pleasure of the Board without term.

ARTICLE VII

COMMITTEES

Section 1. Standing Committees. At the Annual Meeting of the Board of Directors, or at the next following regular Meeting of the Board of Directors the Chairman of the Board shall appoint and the Board shall approve the Chairman of all Standing Committees. The Board of Directors shall have the power to remove any Chairman of a Standing Committee at any time, with or without cause. The Chairman of each Committee, subject to approval of the Board of Directors, shall appoint the remaining members of the Committee to serve until the next Annual Meeting or until their successors are appointed. The Chairman of each Committee and at least one other member of each Committee are required to be members of the Board of Directors.

Section 2. Authority. Standing Committees shall have the authority to make reports and recommendations only to the full Board of Directors except for the Executive Committee which shall have the powers shown in Section 4 G. below.

Section 3. Committee Chairman. The Chairman of each Committee shall have the power to fill vacancies on any Committee until the next Annual Meeting. The Chairman shall have the power to remove any Committee member for lack of participation or for other sufficient reasons.

Section 4. The Corporation shall maintain the following Standing Committees:

A. Distribution Committee. The Distribution Committee shall consist of no less than five (5) members as determined each year by the Chairman. The Distribution Committee shall recommend to the Board of Directors the distribution of income and/or principal funds, or

other property of the Corporation, to eligible organizations, associations, and individuals provided that the purposes set forth in the Certificate of Incorporation are fulfilled. No members of the Distribution Committee shall be permitted to serve for more than six (6) consecutive years.

B. Investment Committee. The Investment Committee shall consist of no less than five (5) members as determined each year by the Chairman. The Committees responsibilities are to deposit liquid assets in suitable financial institutions, and otherwise to invest the Foundations assets, in order to obtain a reasonable return of net income or appreciation, with due regard to the safety of principal; to report to the Board of Directors at least quarterly with regard to the financial standing of the Foundation and its assets; to select and terminate investment managers; and to make recommendation to the Board of Directors for its approval concerning substantive changes in investment strategies and policy. No members of the Investment Committee shall be permitted to serve for more than six (6) consecutive years.

C. Asset Development Committee. The Asset Development Committee shall consist of no less than five (5) members as determined each year by the Chairman. No members of the Asset Development Committee shall be permitted to serve for more than six (6) consecutive years. The Committee's responsibilities are to provide for the development of assets to enable the Corporation to carry out its mission and responsibilities to the communities which it serves; to identify potential new donors and to maintain relationships with current donors; to develop contacts with the professional community for educational and development purposes. The Asset Development Committee shall engage in marketing and public relations activities to provide direction and support for the Corporation's efforts to market itself as a unique and effective vehicle for philanthropy and to enhance the Corporation's relationship with the public.

D. Board Development Committee. The Board Development Committee shall consist of not less than three (3) members as determined each year by the Chairman. All members of the Board Development Committee shall be current members or past members of the Board of Directors. The Board Development Committee shall present to the board of directors nominations for directors and officers. To guide the selection process and enable the Corporation to carry out its mission and responsibilities to the communities which it serves, the Board Development Committee shall maintain a current profile of the membership composition of the board of directors and a roster of candidates for positions on the board of directors and the various committees. The Board Development Committee shall develop programs of orientation, education and regular self assessment for board members, officers and members of the various committees. The Board Development Committee shall review the performance and contributions of incumbent directors and officers and report thereon to the board of directors at least annually.

E. Personnel Committee. The Personnel Committee shall consist of no less than three (3) members as determined each year by the Chairman. No members of the Personnel Committee shall be permitted to serve for more than six (6) consecutive years. The Personnel Committee shall make recommendations to the Board for hiring of staff, termination or employment, terms and conditions of employment, salary and other compensation issues, and all other matters. The Committee shall review the President's recommendations with regard to staff.

F. Scholarship Committee. The Scholarship Committee shall consist of no less than three (3) members as determined each year by the Chairman. No members of the Scholarship Committee shall serve for more than six (6) consecutive years. The Scholarship Committee shall be responsible for recommending to the Board of Directors all policies of the Corporation concerning scholarships, their establishment, or administration; for establishing and maintaining relationships with educational institutions concerned with scholarships; for procedures to disseminate information to potential scholarship recipients and to obtain candidates for scholarships; and in general to oversee the Corporations scholarship activities.

G. Executive Committee. The Executive Committee shall consist of the current Officers and the immediate Past Chairman of the Board. The Executive Committee shall have such authority as may be granted to it by the Board of Directors, and shall in addition be authorized to make administrative decisions from time to time between Board of Directors meetings, subject to timely ratification by the Board of Directors. The Committee shall conduct an annual evaluation of the President.

H. Finance Committee. The Finance Committee shall consist of no less than three (3) members as determined each year by the Chairman. The committee shall meet at least quarterly and shall have the responsibility for all financial matters, excepting those matters assigned to the Investment Committee, concerning the Foundation. The committee shall cause the creation of an annual budget and recommend said budget to the Board of Directors for approval. The Finance Committee shall plan annual cash flow requirements, oversee accounting routines, review all financial reporting, and cause tax returns to be filed on a timely basis. No members of the Finance Committee shall serve for more than six (6) consecutive years.

I. Audit Committee. The Audit Committee shall consist of no less than three (3) members as determined each year by the Board of Directors. The chairman of the committee shall be a member of the Board of Directors. The members of the committee shall be free of any relationship that, in the judgment of the Board of Directors, would interfere with the exercise of the committee member's independent judgment. No members of the Audit Committee shall serve for more than six (6) consecutive years. The committee shall meet at least quarterly and shall have the responsibility for monitoring the Foundation's financial and regulatory reporting and internal control systems. The committee shall recommend to the Board of Directors the selection or replacement of the independent auditors engaged to audit the financial statements of the Foundation, taking into account independence and effectiveness. The audit committee shall review with management the Foundation's annual financial statements, including applicable accounting principles or their application, and any matters reported or recommended by the independent auditors. The committee shall review with the independent auditors their audit report on the annual financial statements including the application of the Foundation's accounting principles. The committee shall report its findings and recommendations to the Board of Directors. The committee may conduct or authorize investigations into any matters within the scope of the committee's responsibilities.

ARTICLE VIII

FINANCES

Section 1. Moneys. The moneys of the Corporation shall be deposited in the name of the Corporation in such bank or trust company as the Board of Directors shall designate, and shall be drawn out only by check signed by persons designated by resolution of the Board of Directors. All notes and other instruments for the payment of money shall be signed or endorsed by officers authorized from time to time by resolution by the Board of Directors.

Section 2. Fiscal Year. The fiscal year of the Corporation shall be the calendar year, unless otherwise determined by the Board of Directors.

ARTICLE IX

BOOKS AND RECORDS

Section 1. Books and Records. The books, accounts and records of the Corporation, except as may be otherwise required by the laws of the State of Connecticut, may be kept inside or outside of the said State at such place as the Board of Directors may from time to time appoint; they shall be open to inspection by the Directors only at such times as the Directors may designate by resolution at a properly convened meeting, except as otherwise provided by charter or by statute.

Section 2. Common reports. The community foundation shall prepare periodic financial reports treating all of the funds which are held by the community foundation, either directly or in component parts, as funds of the community foundation.

ARTICLE X

NOTICES

Section 1. Notices. Except as provided in the By-Laws, whenever the provisions of the statutes or these By-Laws require notice to be given to any director or officer they shall not be construed to mean personal notice; such notice may be given in writing by depositing the same in a post office or letter box, in a postpaid, sealed wrapper, addressed to such director or officer, at his or her address as the same appears in the books of the Corporation; and the time when the same shall be mailed shall be deemed to be the time of the giving of such notice.

Section 2. Waiver. A waiver of any notice in writing, signed by a director or officer, whether before or after the time stated in said waiver for holding a meeting, shall be deemed equivalent to a notice required to be given to any director or officer.

ARTICLE XI

SEAL

Section 1. Seal. The seal of the Corporation shall consist of a circular seal upon the face of which is inscribed the name of the Corporation, the year of its incorporation and the words, Corporate Seal, Connecticut.

ARTICLE XII

VARIANCE POWER

Section l. Variance Power. The Board of Directors shall have the power:

(a) To modify any restriction or condition on the distribution of funds for any specified charitable purposes or to specified charitable purposes or to specified organizations if in the sole judgment of the Board of Directors (without the necessity of the approval of any participating trustee, custodian, or agent), such restriction or condition becomes, in effect, unnecessary, incapable of fulfillment, or inconsistent with the charitable needs of the community or area served;

(b) To replace any participating trustee, custodian, or agent for breach of fiduciary duty under State law; and

(c) To replace any participating trustee, custodian, or agent for failure to produce a reasonable return of net income (within the meaning of 26 CFR§1.170A-9(e)(11)(v)(F)) over a reasonable period of time, as determined by the Board of Directors.

Section 2. Exercise of Powers. The Board of Directors shall exercise the powers described in this section in the best interests of the community foundation.

ARTICLE XIII

FIDUCIARY CONDUCT

Section l. Reasonable return. The Board of Directors shall obtain information and take other appropriate steps with the view to seeing that each participating trustee, custodian, or agent, with respect to each restricted trust or fund that is, and with respect to the aggregate of the unrestricted trusts or funds that are, a component part of the community foundation, administers such trust or fund in accordance with the terms of its governing instrument and accepted standards of fiduciary conduct to produce a reasonable return of net income (or appreciation where not inconsistent with the community foundation's need for current income), with due regard to safety of principal, in furtherance of the exempt purposes of

the community foundation (except for assets held for the active conduct of the community foundation's exempt activities).

Section 2. Common reports. The community foundation shall prepare periodic financial reports treating all of the funds which are held by the community foundation, either directly or in component parts, as funds of the community foundation.

ARTICLE XIV

AMENDMENTS

Section 1. Amendments. Alterations or amendments to these By-Laws may be made by a majority of the Board of Directors present at any properly convened Annual or Special meeting provided that Notice of such alterations and amendments shall be attached to the call of the meeting.

END OF BY-LAWS

Revised June 8, 2012
Revised December 10, 2010
Revised December 12, 2008

Z:\By-laws\ By-Laws Amendments Approved.doc

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 17: MAIN STREET DIRECTORS

Main Street
COMMUNITY FOUNDATION

2014 BOARD OF DIRECTORS

Name	Town of Residence	Affiliation
David Aldieri	Bristol	Aldieri Associates
Michael Brault	Burlington	Ultimate Wireforms, Inc.
Todd Burton	Wolcott	Thomaston Savings Bank
Robert M. Caiaze (Secretary)	Burlington	Wells Fargo Advisors
Kristine J. Dargenio	Plainville	Kaestle Boos Associates
Valerie A. DePaolo	Southington	Sheffy, Mazzaccaro, DePaolo & DeNigris LLP
Val Dumais	Plainville	Community Volunteer
Patricia B. Dunn	Southington	Community Volunteer
David England	Canton	Tunxis Community College
Marguerite P. Fletcher	Bristol	Community Volunteer
Barbara Fontaine	Bristol	Community Volunteer
Arthur Funk	Burlington	Fourslide Spring & Stamping, Inc.
Anita Hamzy	Plymouth	The Hamzy Law Firm, LLC
Daniel J. LaPorte	Southington	Daniel J. LaPorte & Associates
John A. Letizia (Vice Chairman)	Bristol	John A. Letizia, CPA
Janis L. Neri (Chairman)	Southington	Janis L. Neri, CPA/PFS
Mark Peterson	Bristol	ESPN
Susan D. Sadecki (President & CEO)	Harwinton	Main Street Community Foundation
John D. Scarritt (Treasurer)	Farmington	JASSCO, LP
Jeffrey Sonenstein	Bristol	Globe Travel Service
William J. Tracy, Jr. (Past Chairman)	Harwinton	Furey, Donovan, Tracy & Daly PC

Main Street Community Foundation, Inc.
200 Main Street • P.O. Box 2702
Bristol, Connecticut 06011-2702
P: 860.583.6363 • F: 860.589.1252
www.mainstreetfoundation.org

cf NATIONAL STANDARDS

Confirmed in Compliance with
National Standards for U.S. Community Foundations

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 18: MAIN STREET STATEMENT OF ETHICAL PRINCIPLES AND PRACTICES

Main Street
COMMUNITY FOUNDATION

Statement of Ethical Principles and Practices

The Main Street Community Foundation is a Public Foundation, created by private citizens, to assist donors wishing to make philanthropic gifts which will improve the quality of life for all citizens within the towns of Bristol, Burlington, Plainville, Plymouth, Southington and Wolcott.

This policy applies to all Directors, Committee members and Staff of the Main Street Community Foundation.

In its desire to articulate a shared commitment to excellence and a high standard of ethical behavior with other Connecticut Foundations, the Main Street Community Foundation Board of Directors has adopted a set of guiding principles recently outlined by the CT Council for Philanthropy.

Guiding Principles

1. **We act with honesty and integrity. We demonstrate ethical practices in all aspects of our work and avoid conflicts of interest.**
2. **We honor the philanthropic mission of our organization and those who have endowed or who fund our grant making programs.**
3. **We have an identifiable Board that is responsible for the governance and oversight of the organization.**
4. **We affirm and value diversity in its many forms and endeavor to include the perspectives, opinions and experiences of the broadest possible cross- section of our communities to guide the Foundation.**
5. **We are accessible and communicate clearly and promptly with grantees, colleagues, donors and peers. Our relationships with all of these groups are based on mutual respect, candor and confidentiality.**
6. **We provide appropriate, comprehensive and timely information on the Foundation's work to the public, the media, government and all stakeholders.**
7. **We are thoughtful and purposeful in our grant making, and periodically review and evaluate our mission, priorities, policies and practices.**
8. **We are aware of and fulfill our fiduciary and legal responsibilities.**

Confidential Information

Proper management of confidential information is very important to the Foundation. Loyalty to the Foundation includes a commitment not to use or give to others confidential information belonging to the Foundation or to others with whom the Foundation does business. Confidential information includes any information not known to outsiders that has value to the Foundation and could cause harm in the event of premature or inappropriate disclosure. Directors, Committee members and Staff are also prohibited from using, or attempting to use "inside" information for their own personal use, gain or advantage; or providing it to others to gain personal favors or exercise power or influence over others. In addition, Directors, Committee members and Staff shall not release personal or financial donor / grantee information unless given written permission to do so.

At all times, both during and after his or her term of service, every Director, Committee member and Staff member shall hold confidential, and not copy, distribute or reveal, any information, application or list of which he or she has access by reason of his or her position unless specifically authorized by the President/CEO and the Board Chair.

Conflicts of Interest

There are two types of relationships which may give rise to a conflict of interest:

1. **Business Relationships**: A conflict of interest arises in a situation in which (i) the Foundation has business or financial dealings with a Director, Committee member or Staff member individually or with a corporation, partnership, business enterprise, civic or other non-profit organization of which a Director, Committee member or Staff member of the Main Street Community Foundation or a member of his or her immediate family is an officer, director, partner or substantial stockholder or (ii) the primary purpose of a grant from the Foundation's discretionary funds to a not-for-profit organization is made to support a transaction with such a business enterprise. If the Foundation enters into any business or financial dealing with a Director, Committee member or Staff member, or any entity in which they or a member of their family is an officer, director, partner or substantial stockholder, the Foundation shall determine that the dealing is an arms length transaction which is reasonable and fair to the Foundation.

2. **Relationships with Potential Grantees**: A conflict of interest arises in a situation in which the Foundation makes a grant from the Foundation's discretionary funds to a not-for-profit organization of which a Director, Committee member or Staff member or a member of his or her immediate family is an officer, director or trustee. Such conflict also arises out of a similar relationship between a not-for-profit organization and a Staff member or a member of his or her immediate family.

Conflicts of interest extend to possible charges of undue influence or favoritism. Actions, or decisions not to act, taken by the Foundation should be defensible as having been based upon the best judgment of the individuals involved, without any bias in either direction.

The key to this policy is disclosure. Full disclosure of potential conflicts by the individual or individuals who participate in decisions avoids any misunderstanding or later charges of concealment. In some cases, disclosure of a conflict may indicate that the individual should abstain or remove themselves from participating in the decision-making process.

In any situation not specifically covered by the following paragraphs, all persons to whom this Code of Ethics applies must carefully consider any potential conflict of his or her personal interests with the interests of the Main Street Community Foundation. Any Director, Committee member or Staff member uncertain about the appropriate behavior in a given situation should seek guidance from the President/CEO.

Application to Board of Directors

Disclosure

Each Director is under an obligation to the Foundation and to his or her fellow Directors and/or Committee members to inform them of any position he or she holds, and of any business or other activity, which is a conflict of interest at the time the grant, business relationship, action or policy which gives rise to the conflict of interest is under consideration by the Board of Directors.

Abstention

A Director shall abstain or remove themselves from voting on or advocating a position on any action in which he or she has a conflict of interest. The abstention shall be recorded in the minutes of the meeting at which the issue is under consideration. Board members, Committee members and/or Staff shall also refrain from applying for grants on behalf of another organization or scholarships on behalf of themselves and/or a relative.

Application to Staff

Volunteer Service with Other Organization

Staff will exercise caution with respect to actual or perceived conflict of interest in accepting board membership with charitable organizations. If a member of the paid Staff of the Foundation is serving as an officer or Board member of a charitable organization eligible for discretionary grants from the Foundation, the Staff member shall inform the President/CEO, and the President/CEO shall similarly inform the Chairman of the Board of his or her own such activities.

Other Service to Other Organizations

A Staff member may not accept payments, royalties or honoraria for speaking engagements or articles based on his or her Foundation employment. Compensation may be accepted when a speaking engagement or article is on a topic that is not within the scope of the Staff member's duties for the Foundation.

Disclosure

In all cases, such Staff member shall inform the President/CEO in writing of any known relationship which is a conflict of interest. In addition, each Staff member shall inform the President/CEO in writing of any situation where the Staff member acts as an independent contractor with any charitable organization, governmental body or provider of goods or services to the Foundation. Each Staff member shall also inform the President/CEO of any business or other activity in which the Staff member or a member of his or her immediate family is engaged which is a conflict of interest at the time the grant, business relationship, action or policy which gives rise to the conflict of interest is under consideration by the Staff or by the Board of Directors. The President/CEO shall similarly inform the Chair of the Board of Directors of his or her own such activities.

Staffing Adjustments

If a Staff member has a conflict of interest with respect to a grant, business relationship, action or policy under consideration by the Board of Directors or by a committee of the Board, the Staff member shall not exercise any staffing responsibilities (other than the performance of administrative tasks) in connection with that grant, business relationship, action or policy, and the President/CEO shall assign another Staff member to exercise those responsibilities. The members of the Board of Directors or of the committee, as the case may be, shall be informed of the conflict of interest and of the staffing adjustment in advance of their deliberations.

Duties of President/CEO

The President/CEO shall be responsible for the application and interpretation of the above principles relating to Staff members. The President/CEO shall also be bound by the restrictions applicable to other Staff members and shall in all cases advise the Board of Directors just as other Staff members would have the duty to advise the President/CEO of a conflict of interest. At the time a grant application is being considered by the Board of Directors, the President/CEO shall inform the Board of Directors of any conflict of interest of which the President/CEO is aware with respect to the proposed grantee and any Staff member.

General Application

Directors, Committee members and Staff owe a duty to the Foundation to advance its legitimate interests when the opportunity to do so arises. They should not accept gifts of over $100.00 or favors that could compromise their loyalty. In addition, loans to, or guarantees of personal obligations of staff or directors is prohibited.

No deviation from these procedures, and no special consideration by the Board of Directors, Committee members or the Staff of the Main Street Community Foundation, shall be made for an organization with which any Director, Committee member or Staff member, or any member of the immediate family of either, has a relationship giving rise to a conflict of interest.

Directors, Committee members and Staff will be held accountable for adherence to this Code. Staff members who violate the Code will be subject to disciplinary action, including potential termination of employment, depending on the particular circumstances involved. Information regarding possible infringement of the Code by Directors or Committee members will be referred to the Executive Committee for handling as appropriate to the circumstances.

Each year in the month following the commencement of the fiscal year, each Director, Committee member and Staff member shall fill out and update the Code of Ethics Declaration form, to inform the Chair in writing of any known relationship which is, or could be perceived as, a conflict of interest. Updates to the information shall be made as warranted. New Directors, Committee members and Staff should fill out and return the Code of Ethics Declaration form prior to their approval for Foundation service.

Reporting Violations of the Code of Ethics or Applicable Law

Any Director or Committee member with knowledge of or a reasonable cause to believe that there has been a possible violation of this Code of Ethics or suspected illegal activity pertaining to the Main Street Community Foundation, shall report it to the Chair of the Board of Directors. If such possible violation or suspected illegal activity involves the Chair, the report shall be made to any other officer. Any Staff member with knowledge of or a reasonable cause to believe that there has been a possible violation of the Code of Ethics or suspected illegal activity pertaining the Main Street Community Foundation, shall report it to the President/CEO. If such possible violation or suspected illegal activity involves the President/CEO, the report shall be made to the Chair. Retaliation against the Staff member or Director, who in good faith reports the violation or activity including firing, demotion, suspension, harassment, failure to consider the employee for promotion, or any other kind of discrimination is prohibited.

January 2006
Reviewed by Audit Committee January 2010
Reviewed by Audit Committee May 2014

POLICY REVIEWED AND APPROVED BY CORPORATE ACTION OF THE BOARD ON MAY 9, 2014

Main Street Community Foundation, Inc.

Board of Directors, Board Committee and other Foundation Representatives

Annual Disclosure Statement Regarding Ethical Principles and Practices

I am providing this statement in accordance with the "Statement of Ethical Principles and Practices" of the Main Street Community Foundation (the "Foundation").

1. *I have received a copy, read and understand the current Ethical Principles and Practices Policies of the Foundation.*

2. *I understand that I am obligated to keep information concerning the Foundation and its component funds confidential and to make an annual disclosure of all actual or apparent conflicts of interest (as described in the Statement) involving myself or an immediate family member or related person, which means a spouse, a parent, child, spouse of a child, sibling, spouse of a sibling, domestic partner or member of my household.*

3. *I agree to comply with the Statement of Ethical Principles and Practices and understand that the Foundation is a charitable organization and that in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.*

4. *I hereby disclose that I, or my immediate family or related person, have the following relationships that may be a potential conflict of interest:*

Nonprofit Organization Interests Please disclose all official positions which you or any member of your immediate family may have as a director, trustee or officer of any charitable, civic or community organization, as well as any *significant* unofficial roles such as major donor, volunteer, advocate, consultant or advisor to such types of organizations.

NAME OF ORGANIZATION	POSITION HELD/BY WHOM
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Business Interests Please disclose any Board membership, ownership, employment or other business involvement (i.e. consultant, advisor, etc.) that you or any member of your immediate family has in a company or other commercial enterprise that has business relations with the Foundation, including any business partnership with or sponsored by investment management firms engaged by the Foundation.

To the extent you have knowledge of such matters, also please disclose any such positions that you may hold or ownership interests that you may have in a company or other commercial enterprise that has business relations with Foundation grantees or donors.

NAME OF BUSINESS/ORGANIZATION	POSITION HELD/BY WHOM

Other Significant Involvement: (e.g.. membership on foundation boards, consultancies, advisory committees; active political or advocacy role; elected or appointed office). *Use other side for extra space.*

Affirmation

To the best of my knowledge, I have disclosed all potential conflicts of interest with regard to my decision-making role(s) in the Foundation. I will refrain from any votes or participation in any Board or committee action affecting these interests. If I become aware of any Conflicts of Interest in the future in connection with Foundation transactions, I will fully disclose them and refrain from voting on them consistent with the Statement of Ethical Principles and Practices..

My responses to the above questions are complete and correct to the best of my information and belief. I agree that if I become aware of any information that might indicate that this disclosure is inaccurate or that I have not complied with this policy, I will notify the Board Chair or CEO immediately. I further agree to be bound by and to abide by all the terms and conditions of the Foundation's Articles of Incorporation and the amended regulations, as such documents may be periodically amended further.

Affiliation with Foundation	**Name (please print)**
Signature	**Date**

BRISTOL HOSPITAL AND HEALTH CARE GROUP, INC.
OHCA DN: 14-31928-486; AG DN: 14-486-03

EXHIBIT 19: MAIN STREET MISSION, VISION AND CORE VALUES STATEMENT

Main Street
COMMUNITY FOUNDATION

Mission, Vision and Core Values

OUR VISION

To be widely recognized as the comprehensive center for philanthropy in the communities of Bristol, Burlington, Plainville, Plymouth, Southington and Wolcott

OUR MISSION

To enhance the quality of life for both present and future generations in the communities we serve. We accomplish our mission by encouraging and promoting:

- Gift Planning
- Prudent Stewardship of Assets
- Effective Grantmaking
- Community Leadership

OUR CORE VALUES

Excellence, Integrity, Inclusiveness and Transparency in all we do.

Approved by corporate action of the board of directors on December 11, 2009

EXHIBIT 20: SUMMARY OF CHARITABLE FUNDS

A. RESTRICTED FUNDS HELD BY THE HOSPITAL
B. UNRESTRICTED FUNDS HELD BY THE HOSPITAL OR FOUNDATION
C. FUNDS HELD BY THE FOUNDATION
D. FUNDS/TRUSTS HELD BY THIRD PARTIES
E. FUTURE INTERESTS

SCHEDULE A - RESTRICTED FUNDS HELD BY BRISTOL HOSPITAL, INC.

			September 30, 2014 Balances									
Tab	**Donor Name**	**Date of Gift/ Date of Death**	**Held at BHDF, Inc.**	**Held at Bristol Hospital, Inc.**	**Combined Fund Balance**	**Permanently Restricted**	**Temporarily Restricted**	**Unrestricted**	**Gift Instrument(s), Date(s), Section(s)**	**Language in gift instrument**	**Amount/Date(s)**	**Hospital's Analysis of Gift**
1	Barnard, Arthur	Unknown; possibly deceased 04/1968 a resident of Bridgeport, CT (probate court has no records)	$ 192,640.00	$ 162,663.00	$ 355,303.00	$ 172,751.00	$ -	$ 182,552.00	Unknown	Unknown	Unknown	Unknown; historically treated as Unrestricted Endowment
2	Barnes, Carlyle F.	Unknown	$ -	$ 161,760.00	$ 161,760.00	$ -	$ 161,760.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment
3	Barnes, Fuller F.	12/7/1929	$ 111,512.00	$ 300,380.00	$ 411,892.00	$ 100,000.00	$ -	$ 311,892.00	Inter Vivos Trust U/A 12/7/1929, Article Seventh	The Trustee is hereby authorized and directed upon the death of the insured, Fuller F. Barnes, after payment of all expenses and charges incurred in connection with the trust estate including reasonable compensation to the Trustee for its services, to hold the proceeds thereof and distribute the income therefrom upon the following terms and conditions: The proceeds of said policy and the properties into whic [sic] it shall be converted from time to time, shall be set aside by the Trustee as a separate fund to be known as the "Fuller F. Barnes Hospital Fund" and the Trustee shall hold such trust fund for the benefit of The Bristol Hospital, Incorporated, its successors and assigns forever, as a perpetual, charitable trust fund for the benefit of such hospital, its successors and assigns. It shall collect the income thereform, from time to time, and at such time or times during each year in its discretion as it deems advisable, it shall pay to the Treasurer of The Bristol Hospital, Incorporated, the income therefrom or so much as may be necessary for the running expenses of The Bristol Hospital, Incorporated, or its successors or assigns. If at any time the income is not needed for running expenses, the same may be applied to the partial or full payment of capital improvements or equipment for such hospital or its successors or assigns, or for experimental or emergency purposes as may be directed. If, at any time, it may be deemed necessary to apply the income of this trust to expenses, capital improvements, equipment or other purposes beneficial to such hospital, the income may be preserved and added to the principal of the trust hereby created and the same shall thereafter become a part of the principal trust fund and shall be held, managed and invested and the income therefrom distributed in the same manner and with the same powers and duties as the principal trust fund herein created. . .	$100,000; date unknown (no information available regarding mechanism through which Trust was distributed and established as endowment fund)	Unrestricted Endowment
4	Barnes, Lillian H.	5/7/1986	$ 12,392.00	$ 6,863.00	$ 19,255.00	$ 11,113.00	$ -	$ 8,142.00	Last Will and Testament dated May 26, 1982, Article Sixth (B)	I give and bequeath the following sums absolutely to the following charitable corporations situated in the State of Connecticut: […] (B) TEN THOUSAND DOLLARS ($10,000.00) to THE BRISTOL HOSPITAL, INCORPORATED, located in Bristol, Connecticut, to be added to the Endowment Fund of said Hospital, the income only to be used for the general purposes of said Hospital.	$10,000 on or about 7/12/1988	Unrestricted Endowment
5	Bates, Elvira, George H. and Nelson	Circa 1922-1930	$ 1,110.00	$ 35,765.00	$ 36,875.00	$ 1,000.00	$ -	$ 35,875.00	Unknown	Unknown	Unknown	Unknown; historically treated as Unrestricted Endowment
6	Cardiology	Unknown	$ -	$ 2,532.00	$ 2,532.00	$ -	$ 2,532.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment
7	Church, Laura M.	1964	$ 26,282.00	$ 28,271.00	$ 54,553.00	$ 23,589.00	$ -	$ 30,964.00	Will of unknown date	Class I Fund (per correspondence); New Jersey Probate Court produced no documentation	Unknown	Unknown; historically treated as Unrestricted Endowment

SCHEDULE A - RESTRICTED FUNDS HELD BY BRISTOL HOSPITAL, INC.

			September 30, 2014 Balances								
Tab	**Donor Name**	**Date of Gift/ Date of Death**	**Held at BHDF, Inc.**	**Held at Bristol Hospital, Inc.**	**Combined Fund Balance**	**Permanently Restricted**	**Temporarily Restricted**	**Unrestricted**	**Gift Instrument(s), Date(s), Section(s)**	**Language in gift instrument**	**Amount/Date(s)**	**Hospital's Analysis of Gift**
8	Cockings, George E.	4/20/1961	$ 8,971.00	$ 10,317.00	$ 19,288.00	$ 8,044.00	$ -	$ 11,244.00	Bequest under Will dated 3/28/61, Article Fifth	I give and bequeath the sum of FIVE THOUSAND DOLLARS ($5,000.00) to BRISTOL HOSPITAL INCORPORATED, Bristol, Connecticut, and I direct that the same be added to the Endowment Fund of said institution, the income only to be used for the general purposes of said institution.	$5,000 on or about 7/16/1962	Unrestricted Endowment
9	Dailey, May W.	1/2/1952	$ 42,662.00	$ 49,505.00	$ 92,167.00	$ 38,257.00	$ -	$ 53,910.00	Bequest under Will dated 11/26/48, Article Ninth	I give and bequeath to the Bristol Hospital of Bristol, Connecticut the sum of Ten Thousand Dollars ($10,000) with the hope that the governing board of said hospital will hold said fund as part of their general endowment fund, the income only of which shall be used toward the maintenance of said hospital.	$10,000 on or about 10/14/1952	Unrestricted Endowment
10	Driscoll, Hilary S.	6/1/1972	$ -	$ 3,406.00	$ 3,406.00	$ -	$ 3,406.00	$ -	Trust under Will dated 6/3/1959, Article IV(B)(3); terminating distribution	I give, devise and bequeath all the rest, reside and remainder of my estate both real, personal and mixed, wherever situated, of which I may die seized, to Bristol Bank and Trust Co., of Bristol, Connecticut, in trust for the following purposes: […] B. After the death of my said wife; [...] 3. I give and bequeath to Bristol Hospital, Inc. the sum of Twenty-five Hundred (2500) Dollars to be used for the purposes of the hospital classification #2 fund.	$2,500 on 9/13/1973	Restricted Endowment (currently held as Restricted Non-Endowment)
11	Found, R	Unknown	$ -	$ 130,887.00	$ 130,887.00	$ -	$ 130,887.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment
12	Gillette, George E. and Sarah J.	10/25/1932 (Sarah Gillette)	$ 716.00	$ 668.00	$ 1,384.00	$ 645.00	$ -	$ 739.00	Last Will and Testament dated 12/21/1921, and Codicil dated 9/17/1928, Article 11	All the rest and residue of my estate I give, devise and bequeath to The American Trust Company, in trust, to designate the said fund as "The George E. and Sarah J. Gillette" fund and the income to be paid in semi-annual installments to The Bristol Hospital of Bristol in perpetuity.	$645.00 on or about 10/4/1938 (terminating distribution)	Unrestricted Endowment
13	Ingraham, William S. and Grace S. / Ingraham Memorial Fund	12/14/1930 (William Ingraham)	$ -	$ -	$ -	$ -	$ -	$ -	Unknown	Unknown; per memorandum dated 3/19/1970, purpose was "endowment of a free bed"	$24,000 (date unknown)	Restricted Endowment (Free Bed Fund)
14	Ives, Alice H.	7/21/1938	$ 3,343.00	$ 4,548.00	$ 7,891.00	$ 3,000.00	$ -	$ 4,891.00	Trust under Will dated 5/12/1932, Article Ninth	I give IN TRUST to The Bristol Bank and Trust Company of Bristol, Connecticut, the sum of Three Thousand Dollars ($3,000) for the following uses and purposes: a) To Hold, manage and care for the same and to collect the income therefrom; b) To pay the net income of said fund to my brother . . .After funeral and burial expenses have been paid and in the event that any balance remains of the trust fund herein created, I direct that the unexpended balance be used to create a trust fund known as The Alice Hawley Ives Fund, to be held by Bristol Bank and Trust Company, In Trust, for the following uses and purposes: a) To hold, manage, and care for the same and to collect the income therefrom; b) To pay the net income of said fund to The Bristol Hospital, Incorporated, such income to be used as the Board of Trustees may deem wise	$3,000 on or about 2/14/1939	Unrestricted Endowment (trust was bypassed and assets distributed directly to Hospital)
15	Kirkwood, Marion L.	11/12/1990	$ 1,734.00	$ 502.00	$ 2,236.00	$ 1,563.00	$ -	$ 673.00	Bequest under Will dated 7/24/1981, Article Third (20)	In the event that my said husband, ROBERT KIRKWOOD, predeceases me: […] (20) I give and bequeath the sum of ONE THOUSAND FIVE HUNDRED DOLLARS ($1,500.00) to THE BRISTOL HOSPITAL INCORPORATED, Bristol, Connecticut, to be added to the Endowment Fund of said Hospital, the income only from said fund to be used for the general purposes of said Hospital, in memory of Robert Kirkwood and Marion L. Kirkwood.	$1,500 on 3/27/1991	Unrestricted Endowment

SCHEDULE A - RESTRICTED FUNDS HELD BY BRISTOL HOSPITAL, INC.

			September 30, 2014 Balances									
Tab	**Donor Name**	**Date of Gift/ Date of Death**	**Held at BHDF, Inc.**	**Held at Bristol Hospital, Inc.**	**Combined Fund Balance**	**Permanently Restricted**	**Temporarily Restricted**	**Unrestricted**	**Gift Instrument(s), Date(s), Section(s)**	**Language in gift instrument**	**Amount/Date(s)**	**Hospital's Analysis of Gift**
16	Life Insurance	Unknown	$ -	$ 217,033.00	$ 217,033.00	$ -	$ 217,033.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment
17	Meder (first name unknown)	Unknown	$ -	$ 1,362,875.00	$ 1,362,875.00	$ 350,538.00	$ -	$ 1,012,337.00	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Endowment (currently held as Unrestricted Endowment)
18	Mills, Bertha D.	5/1/1996	$ 5,030.00	$ 5,290.00	$ 10,320.00	$ 4,511.00	$ -	$ 5,809.00	Bequest under Will dated 4/8/1949, Article Eighth	I give and bequeath to the Bristol Hospital Inc. of said Bristol the sum of two thousand dollars ($2,000.) in memory of Herbert J. Mills and Delia B. Mills, the principal to be kept intact and the net income used for the charitable purposes of such hospital in perpetuity.	$2,000 (date unknown)	Unrestricted Endowment
19	Mink, Lucy T.	9/24/1968	$ -	$ 247,620.00	$ 247,620.00	$ 43,604.00	$ -	$ 204,016.00	Bequest under Will dated 7/26/1968, Article Sixth	I give and bequeath to the BRISTOL HOSPITAL, INCORPORATED, of Bristol, Connecticut, the sum of TWENTY-FIVE THOUSAND DOLLARS ($25,000.00), the same to be known as the "Lucy Treadway Mink Fund", the income only to be used for the purchase and maintenance of x-ray equipment, accessories and improvements for such hospital. In the event that the governing board of said hospital decide that in any year the income is not needed for such purposes in whole or in part, the governing body may apply part or all of such income for the purchase and maintenance of other hsopital (sic) equipment.	$25,000.00 on or about 6/7/1971	Restricted Endowment
20	Mitchell, George W.	12/10/1929	$ -	$ -	$ -	$ -	$ -	$ -	Bequest under Will dated 11/8/1928, Article 4	I give and bequeath to The Bristol Hospital, Incorporated, of Bristol, the sum of Three Thousand ($3000) Dollars, UPON TRUST, the income thereof to be applied in the payment of charges against such worthy patients as may be deemed advisable by the Directors of the Hospital.	$3,000 on or about 9/3/1930	Restricted Endowment (Free Bed Fund)
21	Montgomery, Mary E. and Silas K.	11/15/1930 (Mary E. Montgomery) 11/24/1923 (Silas K. Montgomery)	$ 25,690.00	$ 29,631.00	$ 55,321.00	$ 23,038.00	$ -	$ 32,283.00	Distribution from Trust established by Silas K. Montgomery of unknown date	Unknown	Unknown	Unknown; historically treated as Unrestricted Endowment
22	Page, May Rockwell	10/5/1959	$ 388,462.00	$ 306,283.00	$ 694,745.00	$ 348,357.00	$ -	$ 346,388.00	Specific Bequest under Will dated 7/31/1956, Article FIFTEENTH (A)	I give and bequeath on the terms hereinafter stated to the several corporations, organizations and instutions hereinafter named shares of the common capital stock of the General Motors Corporation owned by me, in the following amounts, each of said gifts to be accepted and held by the legatee in perpetuity, with power of sale, investment and reinvestment in such securities as would be selected by a prudent investor, the income only to be used in the furtherance of its exclusively religious, charitable, scientific, literary or educational purposes, that is to say: [...] (6) I give to BRISTOL HOSPITAL, of Bristol, Connecticut, five thousand (5,000) shares.	Stock dividends during estate administration: $5,000 (1959-1960); 5,000 shares General Motors Corp. at 56 1/2 per share (c. 1960)	Unrestricted Endowment
23	Pathology Research and Education Fund	Unknown	$ -	$ 3,755.00	$ 3,755.00	$ -	$ 3,755.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment

SCHEDULE A - RESTRICTED FUNDS HELD BY BRISTOL HOSPITAL, INC.

			September 30, 2014 Balances									
Tab	**Donor Name**	**Date of Gift/ Date of Death**	**Held at BHDF, Inc.**	**Held at Bristol Hospital, Inc.**	**Combined Fund Balance**	**Permanently Restricted**	**Temporarily Restricted**	**Unrestricted**	**Gift Instrument(s), Date(s), Section(s)**	**Language in gift instrument**	**Amount/Date(s)**	**Hospital's Analysis of Gift**
24	Plant	Unknown	$ -	$ 27,172.00	$ 27,172.00	$ -	$ 27,172.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment
25	Pond	Unknown; possibly Dwight Pond who died 9/1974, but per probate court his will did not include Bristol Hospital	$ -	$ 47,927.00	$ 47,927.00	$ -	$ 47,927.00	$ -	Unknown	Unknown	Unknown	Unknown; historically treated as Restricted Non-Endowment
26	Root, Katherine R.	circa 1940	$ -	$ -	$ -	$ -	$ -	$ -	Unknown	Unknown; per memorandum dated 3/19/1970, purpose was "income for free care of employees of Veeder-Root, Inc. - Bristol Plant"	$5,000 (date unknown)	Restricted Endowment (Free Bed Fund)
27	Rowe, Rolfe E.	5/6/1985	$ 5,576.00	$ 4,802.00	$ 10,378.00	$ 5,000.00	$ -	$ 5,378.00	Bequest under Will dated 1/19/1978, Article Fifth(a)	I give and bequeath the sum of FIVE THOUSAND DOLLARS ($5,000) to the BRISTOL HOSPITAL, INCORPORATED, to be added to the Endowment Fund of said Hospital, the income only from said Fund to be used for the general purposes of said Hospital.	$5,000 on or about 9/3/1986	Unrestricted Endowment
28	Ryals, Harry N.	2/16/1965	$ 187,629.00	$ 203,068.00	$ 390,697.00	$ 168,257.00	$ -	$ 222,440.00	Residuary Bequest under Will dated 5/12/1948; Article Fifth (e)	Upon the death of my wife, or upon my death in the event that my said wife should predecease me, […] (e) I give, devise and bequeath forty per cent (40%) of all of the remainder of my trust estate, or the residue of my estate to The Bristol Hospital, Incorporated, of Bristol, Connecticut, the income only from said fund to be used as the governing body of said Hospital shall see fit.	$95,321.35 of principal and $4,236.34 of accrued income on or about 11/24/1967	Unrestricted Endowment
29	Sanborn, Florence S.	5/6/1960	$ -	$ 745,915.00	$ 745,915.00	$ -	$ 745,915.00	$ -	Trust under Will dated 9/25/1959, Article SIXTH; terminating distribution	I hereby will, devise and bequeath all the rest, residue and remainder of my estate, real and personal, wheresoever situate, including all failed and lapsed gifts, hereinafter termed the trust estate, to SECURITY-FIRST NATIONAL BANK, Santa Barbara Branch, Santa Barbara, California, a national banking association, in trust, to hold, manage and distribute as hereinafter provided: [...] (b) In the event that my said sister CAROLINE A. SALMON does nor survive me at my death, then the executor of this my Last Will and Testament shall distribute the whole and all of the aforementioned rest, residue and remainder as hereinafter set forth; and, in the event that my sister does survive me at my death, then upon her demise, at which time the trust hereinabove shall distribute the trust estate (principal and the income accrued or held undistributed) as hereinafter set forth, to wit: [...] (4) To the BRISTOL HOSPITAL, INCORPORATED, of Bristol, Connecticut, to be used by the Florence L. Sanborn Medical Library of said Bristol Hospital, Incorporated.	See list of securities distributed on or about 2/1/1967	Restricted Non-Endowment

SCHEDULE A - RESTRICTED FUNDS HELD BY BRISTOL HOSPITAL, INC.

			September 30, 2014 Balances									
Tab	**Donor Name**	**Date of Gift/ Date of Death**	**Held at BHDF, Inc.**	**Held at Bristol Hospital, Inc.**	**Combined Fund Balance**	**Permanently Restricted**	**Temporarily Restricted**	**Unrestricted**	**Gift Instrument(s), Date(s), Section(s)**	**Language in gift instrument**	**Amount/Date(s)**	**Hospital's Analysis of Gift**
30	Shepard, Katherine	6/29/1986	$ 83,949.00	$ 53,750.00	$ 137,699.00	$ 75,280.00	$ -	$ 62,419.00	Residuary Bequest under Will dated 10/12/1971, Article Eighth (F)	All the rest, residue and remainder of my estate, real, personal and mixed, of whatsoever the same may consist and wheresoever situated, including lapsed or void legacies and devises, I give, devise and bequeath as follows: […] F. FIVE PERCENT (5%) thereof, to BRISTOL HOSPITAL, INCORPORATED, of Bristol, Connecticut, in memory of my mother, Marguerite D. Shepard, to be known as the MARGUERITE D. SHEPARD FUND, the income only from said Fund to be used for the general purposes of the Hospital.	$63,659.32 of principal and $11,620.91 of income on or about 11/23/1988	Unrestricted Endowment
31	Shields, John L.	4/30/1970	$ 3,317.00	$ 2,858.00	$ 6,175.00	$ 2,975.00	$ -	$ 3,200.00	Specific Bequest under Will dated 9/25/1961, Article THIRD	All of my stock in Veeder-Root, Incorporated, a corporation located in Hartford, Connecticut, I give and bequeath to THE BRISTOL HOSPITAL, INCORPORATED, Bristol, Connecticut, the same to be added to the endowment funds of said hospital and the income only therefrom to be used for the general purposes of said hospital.	60 Shares Veeder Industries, Inc. valued at $2,557.50 on or about 1/18/1971	Unrestricted Endowment
32	Stevens, Clarence C.	5/28/1971	$ -	$ -	$ -	$ -	$ -	$ -	Trust under Agreement - date unknown	Upon the death of both the Donor and his said wife, the Trustee shall divide the remainder of the trust assets, including any and all property which the Donor or any other person may transfer to this trust by deed or Will or other form of testementary or inter vivos gift, into two hundred (200) equal shares and shall pay over said shares, free and clear of all trusts, as follows: [...] (f) Ten (10) shares to Bristol Hospital Incorporated; one-half (1/2) to be added to the Unrestricted Endowment Funds of said hospital and the other one-half (1/2) to be added to the Restricted Endowment Funds of said hospital, the income only to be used to provide hospital care for charity patients.	$5,201.59 circa 1985	One-half: Unrestricted Endowment; One-half: Restricted Endowment (Free Bed Fund)
33	Treadway, Faith I.	10/2/1983	$ 6,470.00	$ 4,838.00	$ 11,308.00	$ 5,803.00	$ -	$ 5,505.00	Bequest under Will dated 3/8/1972, Article FIFTH	I give and bequeath to THE BRISTOL HOSPITAL, INCORPORATED, of Bristol, Connecticut, the sum of FIVE THOUSAND DOLLARS ($5,000.00), and I direct that the same shall be added to the Endowment Fund of said Hospital, the income only, to be used for the general purposes of said Hospital.	$5,000 on or about 1/12/1987	Unrestricted Endowment
34	Woodruff, Arvilla W.	2/23/1972	$ 28,425.00	$ 33,380.00	$ 61,805.00	$ 25,491.00	$ -	$ 36,314.00	Bequest under Will dated 1/10/1968 and Codicil dated 2/25/1971, Article FIFTH (f)	I give and bequeath the sum of Fifteen Thousand Dollars ($15,000.00) to Bristol Hospital, Incorporated, Bristol, Connecticut, to be added to the Endowment Fund, the income only to be used for the general purposes of said hospital.	$15,000 on or about 12/2/1975	Unrestricted Endowment
35	Woodward, Harold B	1972	$ 1,130,945.00	$ 1,204,850.00	$ 2,335,795.00	$ 1,014,165.00	$ -	$ 1,321,630.00	Trust under Will dated 8/1/1967, terminating distribution Article FOURTH(j)	Upon the death of my wife, LILA T. WOODWARD [...], I give, devise and bequeath the remainder of said trust property [...] as follows: [...] (g) All the rest, residue and remainder of my estate, real, personal and mixed, of whatsoever the same may consist and wheresoever situated, I give, devise and bequeath to The Bristol Hospital, Incorporated, Bristol, Connecticut, to be known as the Harold B. Woodward Memorial Fund, and I direct that said sum shall be added to the Endowment Funds of said hospital, the income only to be used for the general purposes of said hospital.	$355,499 principal, $14,817 income on or about 8/1/1986	Unrestricted Endowment

SCHEDULE A - RESTRICTED FUNDS HELD BY BRISTOL HOSPITAL, INC.

			September 30, 2014 Balances									
Tab	**Donor Name**	**Date of Gift/ Date of Death**	**Held at BHDF, Inc.**	**Held at Bristol Hospital, Inc.**	**Combined Fund Balance**	**Permanently Restricted**	**Temporarily Restricted**	**Unrestricted**	**Gift Instrument(s), Date(s), Section(s)**	**Language in gift instrument**	**Amount/Date(s)**	**Hospital's Analysis of Gift**
36	Wright, Henry C.	12/29/1959	$ 12,238.00	$ 13,854.00	$ 26,092.00	$ 10,974.00	$ -	$ 15,118.00	Bequest under Will dated 4/23/1952, Article Ninth	I give and bequeath to the Bristol Hospital, Incorporated, a charitable corporation organized under the laws of the State of Connecticut, and located in Bristol, Connecticut, the sum of SEVENTY-FIVE HUNDRED DOLLARS ($7,500.00). I direct that this fund shall be added to the endowment fund of said institution and the income only from this fund shall be used for the general purposes of said institution.	$7,500 (date of distribution unknown)	Unrestricted Endowment
37	Wright, Henry C.	12/29/1959	$ 1,355,572.00	$ -	$ 1,355,572.00	$ 1,386,000.00	$ -	$ (30,428.00)	Trust under Will dated 4/23/1952, terminating distribution, Article Third (c)	Upon the death of CLARA M. COVERT, HENRY M. COVERT and BESSIE H. COVERT, I direct my Trustee to pay over the remainder of said trust fund to BRISTOL HOSPITAL, INCORPORATED of Bristol, Connecticut; NEWINGTON HOME AND HOSPITAL FOR CRIPPLED CHILDREN of Newington, Connecticut; and THE MASONIC CHARITY FOUNDATION OF CONNECTICUT, of Wallingford, Connecticut, in equal shares the same to be added to the endowment funds of said institutions, and the income therefrom to be used for the general purposes of said institutions.	$1,362,000 of principal plus $25,315.09 of accrued income, on or about 11/6/07	Unrestricted Endowment
					$ 9,047,633.00							

SCHEDULE B - UNRESTRICTED CHARITABLE FUNDS RECEIVED/HELD BY BRISTOL HOSPITAL, INC. AND/OR BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Donor Name	Date of Gift/ Date of Death	Gift Instrument(s), Date(s), Section(s)	Language in gift instrument	Amount to Hospital/Date(s)	Fund Value as of 9/30/14	Hospital's Analysis of Gift
38	Bruce, Dorothy	10/27/2013	Will dated 7/29/2011, Art. FOURTH	In the event that my Spouse does not survive me for a period of thirty days (30) I give, devise, and bequeath all of my residuary estate to BRISTOL HOSPITAL for any and all purposes that its Board of Directors may deem appropriate.	None yet; estate is in probate	n/a	Unrestricted Non-Endowment
39	Farken, Adelaide	12/13/2013	Will dated 5/30/2012, Art. SIXTH	I direct that my fiduciary hereinafer named divide all the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, which I own or have the right to dispose of at my death, as specified below, and I give, grant, devise and bequeath, in fee simple, the portion of my estate specified to each entity named: [...] B) To Bristol Hospital, of Bristol, Connecticut fifty (50%) percent. Both of these bequests should be recognized as being made by me and my brother, Frank Farken.	None yet; estate is in probate	n/a	Unrestricted Non-Endowment
40	Markwica, Florence J.	3/21/1988	Will dated March 11, 1986, Art. Second (I)	I give, devise and bequeath all my estate whatsoever and wheresoever, real, personal and mixed, to which I may be entitled or which I may have the power to dispose of at my death as follows: […] (I) The sum of TEN THOUSAND ($10,000.00) DOLLARS to BRISTOL HOSPITAL, of Bristol, Connecticut; [...].	$7,120.61 on or about 2/24/1989	n/a	Unrestricted Non-Endowment (deposited at Bristol Hospital Development Foundation)
41	Meyerson, Mary L.	3/7/2003	Will dated 7/1/2002, Art. THIRD(H)	I give and bequeath the sum of FIVE THOUSAND ($5,000,00) DOLLARS to THE BRISTOL HOSPITAL of Bristol, Connecticut, in memory of my husband, SAMUEL MEYERSON.	$5,000 on December 3, 2003	n/a	Unrestricted Non-Endowment (deposited at Bristol Hospital Development Foundation)
42	Pond, G. Phillip	2/27/2004	Outright Gift under Inter Vivos Trust dated February 11, 2000, Article 2.01(b)(iii)	2.01 General. Upon the death of the Donor, the Trustee shall ascertain the total amount in a fund comprised of the then remaining principal and any undistributed income of the Trust Estate plus any amount added to the Trust Estate by any other provision of this Agreement or otherwise, and the Trustee shall pay over and distribute such total amount, or shall hold such total amount in further trust, as hereinafter set forth: [...] (b) The Trustee shall pay over and distribute one-half (1/2) of such total amount (or all of such total amount if the Donor's former wife, Ruth Manross Pond, is not then living or if she is then living but she has remarried since their divorce) as follows: [...] (iii) Twenty-five percent (25%) of such amount to Bristol Hospital, Bristol, Connecticut, for its general uses and purposes.	$75,000 on or about 11/24/2004, $76,997 on or about 2/2006, and $940 on or about 3/30/2007	n/a	Unrestricted Non-Endowment (deposited at Bristol Hospital Development Foundation)
43	Treadway, Morton	9/16/1995	Will dated 1/19/1989, Art. THIRD (b)(iv)	All the rest, residue, and remainder of my estate, real, personal and mixed […] I give, devise and bequeath as follows: […] (b) TWENTY-FIVE PERCENT (25%) thereof to the following named charities in the following proportions: […] (iv) FIFTEEN PERCENT (15%) thereof to BRISTOL HOSPITAL, INC., of Bristol, Connecticut, absolutely and forever.	$24,000 on or about 1/9/1997, $1,371.16 on or about 8/20/1997, $27.95 on or about 4/23/1998, $30.33 on or about 4/23/1998	n/a	Unrestricted Non-Endowment (deposited at Bristol Hospital Development Foundation)
44	Tyrrell, Elizabeth and Jay	12/2/1988; (J. Tyrrell deceased 12/1/1990; E. Tyrrell deceased 5/24/2010)	Trust dated 12/2/1998, Art. II (3)	Upon the death of the survivor of the two Recipients […], all property then belonging to the income or principal of the Trust, other than any amount due the recipients, shall be distributed to the Bristol Hospital; provided that if at the time of distribution, Bristol Hospital is not an organization described in Section 170(c), Section 2055(a) and 2522(a) all such property shall be distributed to such one or more organizations described in said sections and in such shares as the Trustee in its discretion determine.	$104,587 on or about 3/22/2011; $1,004.78 on or about 4/21/2011	n/a	Unrestricted Non-Endowment (deposited at Bristol Hospital Development Foundation)

SCHEDULE B - UNRESTRICTED CHARITABLE FUNDS RECEIVED/HELD BY BRISTOL HOSPITAL, INC. AND/OR BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

45	Various Sources BHDF Fund 1000 Cash	n/a	n/a	Unrestricted - Cash Account - Other	n/a	$ 4,554.84	Unrestricted Non-Endowment
46	Various Sources BHDF Fund 1001 Cash	n/a	n/a	Unrestricted	See Exhibit	$ 141,701.46	Unrestricted Non-Endowment
47	Various Donors BHDF Fund 1004 Cash	n/a	n/a	Unrestricted - Vendor Sales	See Exhibit	$ 9,145.06	Unrestricted Non-Endowment
48	Various Donors Unrestricted (Health) BHDF Fund 1201	n/a	n/a	Unrestricted - held as temporarily restricted account	See Exhibit	$ 330,346.65	Unrestricted Non-Endowment
49	Various Donors Unrestricted (Operations) BHDF Fund 1201-1	n/a	n/a	Unrestricted (held as temporarily restricted account)	See Exhibit	$ 88,464.38	Unrestricted Non-Endowment
50	Various Donors Unrestricted BHDF Fund 1402-1	n/a	n/a	Unrestricted	See Exhibit	$ -	Unrestricted Non-Endowment
51	Various Donors Unrestricted Fund 4000	n/a	n/a	Unrestricted	See Exhibit	$ -	Unrestricted Non-Endowment
						$ 574,212.39	

SCHEDULE C - FUNDS HELD BY BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Fund Name	Fund #	Cash Account as of 9/30/14	Investment Account as of 9/30/14	Total	Fund Purposes	Date of Donation(s)	Hospital's Analysis of Gift
52	AIDS/HIV	1211	$ -	$ 1,352.14	$ 1,352.14	AIDS/HIV patient care	See Exhibit	Restricted Non-Endowment
53	Additional Cancers	1239	$ -	$ 24,383.00	$ 24,383.00	Cancer screenings	See Exhibit	Restricted Non-Endowment
54	Ball (Auxiliary) - 2013	1002	$ 97,865.34	$ -	$ 97,865.34	General purposes of Bristol Hospital	See Exhibit	Unrestricted Non-Endowment
55	Beekley Center For Breast Health and Wellness	1035-1	$ 56,250.47	$ -	$ 56,250.47	Funds for construction of breast care center; construction of center was completed 10/2013; all funds pledged by Beekley Family Foundation and Beekley Corporation have been paid to BHDF, Inc. per agreement to accellerate gift payment timeline	See Exhibit	Restricted Non-Endowment
56	Behavioral Health	1026/1226	$ 89.54	$ 5,210.38	$ 5,299.92	Crisis services, inpatient behavioral health care, inpatient medical detoxification, ambulatory detoxification, partial hospitalization programs, intensive outpatient treatment, outpatient services	See Exhibit	Restricted Non-Endowment
57	Breast Health Mammograms	1035/1235	$ (31,644.00)	$ 530,943.37	$ 499,299.37	Free or low cost mammograms/ultrasounds/surgery/MRI for women and men	See Exhibit	Restricted Non-Endowment
58	Bristol Hospital Learning Center	1024/1224	$ (23,190.70)	$ 65,758.85	$ 42,568.15	Tools and supplies outside of the budget of the learning center, including CNA scholarships	See Exhibit	Restricted Non-Endowment
59	Cancer Care Center (aka Oncology)	1013/1213	$ 17,244.96	$ 88,580.07	$ 105,825.03	Improve care given to oncology patients; publications and subscriptions, physical comfort items for clinic, education for staff, assistance for oncology patients for medication, supplies, respite care, assistance in home; construction of Healing Garden	See Exhibit	Restricted Non-Endowment
60	Cardiac Unit	1254	$ -	$ 80.56	$ 80.56	Funds are used for the benefit of the inpatient Cardiac Unit	See Exhibit	Restricted Non-Endowment
61	Charlotte Johnson Hollfelder	1055	$ 260.73	$ -	$ 260.73	Improve quality of care/life for patients who do not have the financial means, including physical comfort items, assistance for ancillary needs such as medications, supplies, respite care, assistance in the home, transportation and miscellaneous one time expenses for families in crisis	See Exhibit	Restricted Non-Endowment
62	Colon Cancer Endowment aka Colo Rectal Program	1062/1262	$ (4,536.87)	$ 175,484.19	$ 170,947.32	Educate the greater Bristol area about risk factors, signs and symptoms, prevention measures and detection techniques, to increase earlier detection and compliance with regular screenings; heighten awareness and education for all, increase screening according to American Cancer Society recommendations, prevention by polyp diagnosis, increase in earlier detection, access to screening	See Exhibit	Restricted Non-Endowment
63	Counseling Center of Bristol Hospital	1026-1	$ 2,298.89	$ -	$ 2,298.89	To benefit the Counseling Center, which provides counseling to individual adults, couples and families; fund was started to receive donations in memory of a deceased patient	See Exhibit	Restricted Non-Endowment

SCHEDULE C - FUNDS HELD BY BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Fund Name	Fund #	Cash Account as of 9/30/14	Investment Account as of 9/30/14	Total	Fund Purposes	Date of Donation(s)	Hospital's Analysis of Gift
64	Crohn's Disease	1234	$ -	$ 16.29	$ 16.29	No documentation available as to the purpose of these funds	See Exhibit	Restricted Non-Endowment
65	Denim Days	1005	$ 4,820.33	$ -	$ 4,820.33	Employee fundraiser for dress down days; funds raised for different purposes on each occasion and transferred to subject fund	See Exhibit	Restricted Non-Endowment
66	Diabetes Education	1063/1263	$ (3,811.00)	$ 119,433.48	$ 115,622.48	Improve the quality of care/life for patients with diabetes; diabetes education and visits for appropriate patients, dietitian RN, diabetes care supplies, ancillary care (foot screenings, eye exams), endocrinology care, glucose monitors	See Exhibit	Restricted Non-Endowment
67	Emergency Room	1019/1219	$ (22,467.08)	$ 26,903.90	$ 4,436.82	Improve the care to emergency patients; publications and subscriptions, physical comfort items for clinic, education for staff, assistance for department that is not in budgeted funds	See Exhibit	Restricted Non-Endowment
68	EMS	1019-2	$ 1,025.00	$ -	$ 1,025.00	For ambulance corps communications	See Exhibit	Restricted Non-Endowment
69	ER Renovations	1019-1	$ 3,600.00	$ -	$ 3,600.00	Original fund purpose was for Emergency Room expansion; funds on hand are for renovation of Trauma Room 1 at Bristol Hospital Emergency Room	See Exhibit	Restricted Non-Endowment
70	Golf Tournament - 2013 and 2014	1050	$ 142,050.09	$ -	$ 142,050.09	Fundraiser for the general benefit of Bristol Hospital	See Exhibit	Unrestricted Non-Endowment
71	Hanifa Ahmad Fund (formerly known as Dr. Banerjee Fund)	1068	$ 16,492.45	$ -	$ 16,492.45	Maintenance of pathology lab equipment	See Exhibit	Restricted Non-Endowment
72	Heartworks	1038	$ 1,538.08	$ -	$ 1,538.08	To benefit Heartworks Cardiac Rehabilitation program at Bristol Hospital	See Exhibit	Restricted Non-Endowment
73	Home Care	1049/1249	$ (2,023.81)	$ 18,927.55	$ 16,903.74	Improve the quality of care/life of patients of Bristol Hospital and Bristol Hospital Homecare not otherwise provided by the Palliative Care Fund or Hospice Fund; funds for noninsured or underinsured patients, education for staff	See Exhibit	Restricted Non-Endowment
74	Hospice	1012/1212	$ 32,801.75	$ 231,658.40	$ 264,460.15	Improve the quality of care/life of Bristol Hospital hospice patients; homemaker care for housebound Bristol Hospital patients, additional homemaker home health aide services, special items to acknowledge special occasions, supplies and equipment to maintain hospice patient rooms, publications, presentations for patients, volunteers and staff, education for staff, volunteers and community, patient comfort items, clinical visits not covered by insurance, bereavement follow-up	See Exhibit	Restricted Non-Endowment

SCHEDULE C - FUNDS HELD BY BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Fund Name	Fund #	Cash Account as of 9/30/14	Investment Account as of 9/30/14	Total	Fund Purposes	Date of Donation(s)	Hospital's Analysis of Gift
75	ICU	1030/1230	$ 11,557.40	$ 3,866.51	$ 15,423.91	Completion of expanded intensive care unit (substantially completed)	See Exhibit	Restricted Non-Endowment *Note: grant funds not expended must be returned to Kresge Foundation
76	Ingraham Manor	1031/1231	$ (50,057.01)	$ 76,096.53	$ 26,039.52	Improve the quality of life of Ingraham Manor residents; publications, subscriptions, videos, training materials, physical comfort items for clinic, recreation supplies, equipment, entertainment, recreation trips, rehab equipment, bariatric equipment * Dorothy Noel, who died on 5/21/05, made a gift under her will which would have been applied to this fund; however, her estate was insufficient to warrant probate proceedings, so her son, Francis Hines, made a donation in her memory to the Foundation; the donation was originally deposited to an Unrestricted account, but will be transferred to this Fund	See Exhibit	Restricted Non-Endowment
77	LaPlume Nursing Education Fund	1025/1225	$ (31,764.50)	$ 61,202.02	$ 29,437.52	To provide educational opportunities for nursing staff, such as providing help with expenses for attending health care educational offerings	See Exhibit	Restricted Non-Endowment
78	Maternity (LDRP)	1040/1240	$ -	$ 2,202.59	$ 2,202.59	To benefit Maternity services at Bristol Hospital (no documentation available)	See Exhibit	Restricted Non-Endowment
79	Palliative Care	1051/1251	$ (40,292.63)	$ 259,385.19	$ 219,092.56	Improve the quality of life/care of patients at Bristol Hospital and Bristol Hospital Home Care; bereavement care for non-hospice patients, home maker care for housebound for Bristol Hospital Special Touch patients, clinical visits not otherwise covered by insurance, education for staff, volunteers, community, special items for special occasions, patient comfort items, equipment, medical supplies, pharmaceutical items	See Exhibit	Restricted Non-Endowment

SCHEDULE C - FUNDS HELD BY BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Fund Name	Fund #	Cash Account as of 9/30/14	Investment Account as of 9/30/14	Total	Fund Purposes	Date of Donation(s)	Hospital's Analysis of Gift
80	Parent & Child Center	1021/1221	$ 74,628.78	$ 295,647.08	$ 370,275.86	To provide information, programs and services to assist parents to raise healthy happy children, including publications, subscriptions, supplies for the center, education for staff, underwrite the operation of the center, assuring quality programs for the community it serves. * Note that donors Justine and Donald D'Alesio entered into a Gift Annuity Agreement with the Foundation on 10/30/06 and made a gift of $20,000 to this Fund in accordance with the terms of the Agreement; both of the donors are presently living ** Note that in 2006, the Parent & Child Center received a $200,000 gift from the Bristol Hospital Auxiliary that appears to have been established as an endowment and is held at the Foundation *** Note that the boards of Bristol Hospital and Bristol Hospital Foundation have voted to create a separate public charity for the Parent and Child Center, in order to retain government and private funding (pending Attorney General Approval)	See Exhibit	Restricted Non-Endowment; except as to 2006 $200,000 gift from Auxiliary, which is Restricted Endowment; adequate funds need to be retained to satisfy terms of D'Alesio Gift Annuity
81	Parent & Child Center - Blue Ribbon Fund	1021-1	$ (1,180.00)	$ -	$ (1,180.00)	Annual fundraiser for child abuse prevention	See Exhibit	Restricted Non-Endowment
82	Pastoral Care	1058/1258	$ (272.48)	$ 656.96	$ 384.48	Funds are used in the discretion of Reverend Fowler (Bristol Hospital Pastor) for social services and programs; funds were donated in Reverend Fowler's name for services he has provided for funerals and the like in connection with his role at Bristol Hospital	See Exhibit	Restricted Non-Endowment
83	PeriOperative Center	1053/1253	$ (17,595.88)	$ 25,180.63	$ 7,584.75	For construction of 50,000 square foot perioperative center (substantially completed)	See Exhibit	Restricted Non-Endowment
84	Pharmacy	1015/1215	$ (3,174.00)	$ 3,658.74	$ 484.74	Funds are used for special programs and books that the Pharmacy department requires outside of budgeted funds and for the patient education program and anticoagulant program (educational programs)	See Exhibit	Restricted Non-Endowment
85	Putnam - Nursing (aka Kent and Doris Putnam Memorial Scholarship)	1046/1246	$ -	$ 3,361.32	$ 3,361.32	Interest earned on gift awarded (1) to graduating Bristol Eastern High School senior pursing career in health care field, with preference given to those pursuing career as registered nurse; or (2) to Bristol Hospital employees furthering education in health care field, with preference given to individuals advancing clinical (as opposed to administrative) expertise	3/4/1997	Restricted Endowment
86	Schooltime Daycare	1060	$ 330.71	$ -	$ 330.71	To improve the quality of care for Schooltime Child Care Center students; purchase of equipment, physical comfort items for school, staff development; Schooltime Child Care Center closed in 2012	See Exhibit	Restricted Non-Endowment

SCHEDULE C - FUNDS HELD BY BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Fund Name	Fund #	Cash Account as of 9/30/14	Investment Account as of 9/30/14	Total	Fund Purposes	Date of Donation(s)	Hospital's Analysis of Gift
87	Senior Eye Care	1067/1267	$ (7,589.70)	$ 87,364.15	$ 79,774.45	To improve the care given to patients over 65 years old, including eye care; cataract care, stretchers for cataract surgery, community wide cataract detection screening, offset cataract co-insurance for seniors with financial need, pay for glasses and eye exams, payment to Bristol Hospital and Opthalmologist for uninsured patients for laser surgery, cataract surgery and retinopathy, physical comfort items for clinic, staff education for working with geriatric population, assistance with medications, supplies, respite care and assistance in the home, wheelchair service to physicians' offices	See Exhibit	Restricted Non-Endowment
88	Social Service	1241	$ -	$ 328.18	$ 328.18	To provide tools and supplies that are outside of the budget	See Exhibit	Restricted Non-Endowment
89	TDK (Thomas D. Kennedy, III) Donor Restricted	1056/1256	$ 2,060.00	$ 19,192.74	$ 21,252.74	Donor advised fund of Thomas D. Kennedy, III; was used as holding fund for various other donations which have since been transferred to other funds	See Exhibit	Restricted Non-Endowment
90	Wine Tasting - 2013 and 2014	1069	$ 51,686.57	$ -	$ 51,686.57	General purposes of Bristol Hospital	See Exhibit	Unrestricted Non-Endowment
					$ 2,403,876.25			

SCHEDULE D - FUNDS/TRUSTS HELD BY THIRD PARTIES FOR THE BENEFIT OF BRISTOL HOSPITAL, INC. AND/OR BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Donor Name/ Fund Name	Date of Death/ Date of Establishment	Trustee/Custodian Name Account Number	Fair Market Value of Corpus Held By Third Party as of 9/30/14	Gift Instrument(s), date(s), section(s)	Language in gift instrument	Amount to Hospital/ Date(s)	Hospital's Analysis of Gift
91	Atkins, Grace E.	10/29/1965	Bank of America, N.A. Acct # 42-09-900-8555077	$ 1,512,478.00	Last Will and Testament dated September 27, 1961, and Codicil dated October 28, 1965; Article EIGHTEENTH(b)	All the rest, residue and remainder of my estate, real personal and mixed, of whatsoever the same may consist and wherever situated, I give, devise and bequeath to the BRISTOL BANK AND TRUST COMPANY […], IN TRUST, and I direct said Trustee to hold, manage and control the same and after payment of any necessary expenses, including compensation to my said Trustee, to pay over the income, quarterly if practicable, but in any event not less than semi-annually, as follows: [...] (b) One-third (1/3) thereof to the BRISTOL HOSPITAL, INC. in Bristol, Connecticut to be used for its general purposes.	See Exhibits	Income distributed by Trustee is fully expendable for general purposes and is unrestricted
92	Barnes, John	1942	Bank of America, N.A. Acct # 42-09-900-8555078	$ 3,554,603.43	Last Will and Testament dated February 15, 1942, Article 4	All the remainder of my estate said trustee shall hold in trust for the benefit of The Bristol Hospital, Incorporated, of said Bristol, and The Newington Home for Crippled Children of Newington, and shall pay over the interest, one-half to said hospital and one-half to said Newington Home, as it accrues forever. If at any time either of said institutions should cease to exist, the other shall receive the entire income of said fund.	See Exhibits	Income distributed by Trustee is unrestricted
93	Bristol Hospital Development Foundation, Inc. Fund	10/15/1999	Main Street Foundation	$ 201,150.89	Designated Fund Agreement dated 10/15/1999, Section 4	An annual amount shall be distributed from the fund to the [Bristol Hospital] Development Foundation, or its successors, which annual amount shall be equal to a percentage of the fair market value of the assets of the Fund, which value shall be determined annually on the first day of each year. Such percentage shall be determined from time to time in accordance with the [Main Street] Foundation's "spending policy", a copy of which is attached hereto [...]. Notwithstanding anything contained herein, any amounts distributed from the Fund to the organization shall be used solely for purposes allowed by Internal Revenue Code Section 501(c)(3). * Note that funds raised through the Bristol Brass Designated Fund Agreement dated 10/15/1999 were transferred to this fund upon termination of that Agreement.	See Exhibits	Distributions received by the Foundation are unrestricted, provided that such purposes are allowed by I.R.C. §501(c)(3)
94	Manross, Frederick	6/12/1989	Bank of America, N.A. Acct # 42-09-900-8555255	$ 2,051,999.59	Trust under Agreement Dated August 5, 1975, Article Third(a)	Upon the decease of the survivor of the Donor and said wife of the Donor, and upon performance of the provisions of the preceding paragraphs, the Trustee shall then distribute or otherwise transfer all the remaining assets of the trust estate as it shall then be constituted and in the proportions hereto designated as follows: (a) Thirty-five per centum (35%) to be retained by the Trustee in perpetual trust to be known as the MANROSS TRUST in memory of the Donor's parents, Arthur N and Della H Manross, and of the Donor's paternal grandparents, Frederick N and Sylvia E Manross, the income from said trust to be distributed annually and in perpetuity in equal shares to the Bristol Hospital Incorporated in Bristol Connecticut and to the City of Bristol Connecticut for the Frederick N Manross Memorial Library in the village of Forestville.	See Exhibits	Income distributed by Trustee is unrestricted
95	Pond, E. Leroy	4/15/1961	Bank of America, N.A. Acct # 42-09-900-8547331	$ 958,089.81	Last Will and Testament dated February 16, 1955, Article Fourth	Upon the death of my said wife (or on my death if my said wife shall not survive me) this trust shall continue primarily for the benefit of the following institutions: The Bristol Hospital, of Bristol, Connecticut; The Church of Christ, Congregational, of Newington, Connecticut, and The Terryville Congregational Church, of Terryville, Connecticut. My trustee shall have complete discretion as to income and principal payments to said institutions and shall not be obligated to equalize payments among the said institutions. It would be my desire that a free bed be established in the Bristol Hospital for the benefit of residents of Terryville, in memory of my wife's mother, Emma Caroline Karman...If at any time my trustee shall deem it desirable, it may terminate the trust paying out the entire assets thereof to said three institutions. If at any future time during the continuance of this trust said trustee shall deem that any one or more of said institutions are unworthy of support, it may make payments of income and principal to some similar institution.	See Exhibits	Income distributed by Trustee is unrestricted (bed fund language is precatory)

SCHEDULE D - FUNDS/TRUSTS HELD BY THIRD PARTIES FOR THE BENEFIT OF BRISTOL HOSPITAL, INC. AND/OR BRISTOL HOSPITAL DEVELOPMENT FOUNDATION, INC.

Tab	Donor Name/ Fund Name	Date of Death/ Date of Establishment	Trustee/Custodian Name Account Number	Fair Market Value of Corpus Held By Third Party as of 9/30/14	Gift Instrument(s), date(s), section(s)	Language in gift instrument	Amount to Hospital/ Date(s)	Hospital's Analysis of Gift
96	Pond, Mary K.	5/8/1970	Bank of America, N.A. Acct. # 42-09-900-8547332	$ 241,029.64	Last Will and Testament dated February 16, 1955, Article Third	Upon the death of my said husband (or on my death if my said husband shall not survive me) this trust shall continue primarily for the benefit of the following institutions: The Bristol Hospital, of Bristol, Connecticut; The Church of Christ, Congregational, of Newington, Connecticut, and The Terryville Congregational Church, of Terryville, Connecticut. My trustee shall have complete discretion as to income and principal payments to said institutions and shall not be obligated to equalize payments among the said institutions. It would be my desire that a free bed be established in the Bristol Hospital for the benefit of residents of Terryville, in memory of my mother, Emma Caroline Karman...If at any time my trustee shall deem it desirable, it may terminate the trust paying out the entire assets thereof to said three institutions. If at any future time during the continuance of this trust said trustee shall deem that any one or more of said institutions are unworthy of support, it may make payments of income and principal to some similar institution.	See Exhibits	Income distributed by Trustee is unrestricted (bed fund language is precatory)
				$ 8,519,351.36				

SCHEDULE E - UNMATURED FUTURE INTERESTS

Tab	Donor Name	Date of Death	Trustee/Custodian Name Account Number	Fair Market Value of Corpus	Gift Instrument(s), date(s), section(s)	Language in gift instrument	Amount to Hospital/ Date(s)	Hospital's Analysis of Gift
97	Pond, G. Phillip	2/27/2004	Paul Orth	$400,000 (approximate current value per correspondence from Trustee)	Remainder interest under Inter Vivos Trust dated February 11, 2000, Article 2.02(b) Ruth Manross Pond, measuring life, is still living and has not remarried	2.01 General. Upon the death of the Donor, the Trustee shall ascertain the total amount in a fund comprised of the then remaining principal and any undistributed income of the Trust Estate plus any amount added to the Trust Estate by any other provision of this Agreement or otherwise, and the Trustee shall pay over and distribute such total amount, or shall hold such total amount in further trust, as hereinafter set forth: [...] (a) If the Donor's former wife, Ruth Manross Pond, is then living and if she has not remarried since their divorce, the Trustee shall hold one-half (1/2) of such separate amount in a separate trust (said trust to be known as "Trust R"); [...] 2.02 Trust R. The Trustee shall hold Trust R in trust for the following uses and purposes: [...] (b) Upon the death of the Donor's former wife, or upon her remarriage, whichever shall first occur, the Trustee shall ascertain the total amount in a fund comprised of the then remaining principal, and undistributed income of Trust R, and the Trustee shall pay over and distribute such total amount as follows: [...] (iii) Twenty-five percent (25%) of such amount to Bristol Hospital, Bristol, Connecticut, for its general uses and purposes. Any portion not disposed of by the foregoing provisions of this Section shall be added proportionally to such portion or portions as shall be disposed of by such provisions and shall follow the disposition of the latter portion or portions in all respects	None	Unmatured future interest; principal and income unrestricted upon distribution