CML HEALTHCARE INC.

ANNUAL INFORMATION FORM

March 29, 2011

TABLE OF CONTENTS

FINANCIAL INFORMATION AND CURRENCY 1
EXCHANGE RATES 1
REFERENCES TO CML 2
CAUTION REGARDING FORWARD-LOOKING STATEMENTS 2
SUPPLEMENTAL DISCLOSURE 3
CORPORATE STRUCTURE 4
DESCRIPTION OF THE BUSINESS 9
RISK FACTORS 28
DIRECTORS AND EXECUTIVE OFFICERS 41
DIVIDEND RECORD AND POLICY 46
DESCRIPTION OF CAPITAL STRUCTURE 46
MARKET FOR SECURITIES 47
LEGAL PROCEEDINGS AND REGULATORY ACTIONS 47
INTEREST OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS 48
TRANSFER AGENT AND REGISTRAR 48
MATERIAL CONTRACTS 48
EXPERTS 48
ADDITIONAL INFORMATION 48

SCHEDULE A - CHARTER OF THE AUDIT COMMITTEE OF CML HEALTHCARE INC.

FINANCIAL INFORMATION AND CURRENCY

In this Annual Information Form, references to $, C$ and "Canadian dollars" are to the lawful currency of Canada and references to U.S.$ are to the lawful currency of the United States of America. All dollar amounts herein are in Canadian dollars unless otherwise noted.

EXCHANGE RATES

The following table reflects (i) the high and low rates of exchange for one U.S. dollar, expressed in Canadian dollars, during the periods noted, (ii) the rates of exchange at the end of such periods, and (iii) the average of such exchange rates during such periods, based on the noon spot rate of exchange.

	Twelve Months Ended December 31,	
	2009	**2010**
High for the period	$1.3000	$1.0778
Low for the period	$1.0292	$0.9946
Rate at the end of the period	$0.9555	$1.0054
Average noon spot rate for the period	$1.1420	$1.0299

On March 29, 2011 the noon spot rate of exchange as reported by the Bank of Canada for conversion of U.S.$ to $ was U.S.$0.9761.

CML HEALTHCARE INC.

ANNUAL INFORMATION FORM

In this Annual Information Form, unless otherwise indicated, all dollar amounts are expressed in Canadian dollars and the statistical and financial data are presented as of December 31, 2010.

REFERENCES TO CML

Unless otherwise stated, references in this Annual Information Form ("**AIF**") to "CML" refer to both CML HealthCare Inc., the resulting entity from the amalgamation of CML Healthcare Inc. and 2260408 Ontario Limited completed under the plan of arrangement referred to below under "Corporate Structure — Name, Address and Incorporation" and to all predecessors, including, without limitation, CML Healthcare Income Fund (the "**Fund**").

CAUTION REGARDING FORWARD-LOOKING STATEMENTS

This document includes forward-looking statements within the meaning of certain securities laws, including the "safe harbour" provisions of the *Securities Act* (Ontario) and other provincial securities law in Canada. These forward-looking statements include, among others, statements with respect to our objectives, goals and strategies to achieve those objectives and goals, as well as statements with respect to our beliefs, plans, objectives, expectations, anticipations, estimates and intentions. The words "may", "will", "could", "should", "would", "suspect", "outlook", "believe", "plan", "anticipate", "estimate", "expect", "intend", "forecast", "objective" and "continue" (or the negative thereof), and words and expressions of similar import, are intended to identify forward-looking statements.

By their very nature, forward-looking statements involve inherent risks and uncertainties, both general and specific, which give rise to the possibility that predictions, forecasts, projections and other forward-looking statements will not be achieved. Certain material factors or assumptions are applied in making forward-looking statements and actual results may differ materially from those expressed or implied in such statements. We caution readers not to place undue reliance on these statements, as a number of important factors, many of which are beyond our control, could cause our actual results to differ materially from the beliefs, plans, objectives, expectations, anticipations, estimates and intentions expressed in such forward-looking statements. These factors include, but are not limited to: dependence on government-based revenues in Canada; general economic conditions; pending and proposed legislative or regulatory developments in Canada including the impact of changes in laws, regulations and the enforcement thereof; reliance on funding models in Canada; intensifying competition resulting from established competitors and new entrants in the businesses in which we operate; our ability to complete strategic acquisitions and to integrate our acquisitions successfully; insurance coverage of sufficient scope to satisfy any liability claims; operational and infrastructure risks including possible equipment failure and performance of information technology systems; fluctuations in total patient referrals; technological change and obsolescence; loss of services of key senior management personnel; privacy laws; ability to pay dividends in the future; structural subordination of common shares; leverage and restrictive covenants; fluctuations in cash timing and amount of capital expenditures; tax-related risks; unpredictability and volatility of the price of common shares; dilution; and future sales of common shares. Additional factors related to business operations in the U.S. imaging market include, but are not limited to: potential termination of the arrangements with contracted radiology practices; fluctuations in total patient referrals; changes in third-party reimbursement rates or methodology; increased pressure to control healthcare costs; increased competition; technological change; exposure to professional malpractice liability; potential termination of the relationship with Johns Hopkins; currency fluctuations; ability to grow business in the U.S.; U.S. income tax matters; different regulatory environment characterized by extensive regulation; penalties arising from failure to comply with all regulations; federal and state fraud and abuse laws; loss of licensing, certification or accreditation; Certificate of Need regulations; privacy legislation; legislative change affecting prices that physicians or suppliers can charge; avoidance of fee-splitting; environmental health and safety laws; and the uncertainty of, and changes in, the U.S. healthcare regulatory environment.

We caution that the foregoing list of important factors that may affect future results is not exhaustive. When reviewing our forward-looking statements, investors and others should carefully consider the foregoing factors and other uncertainties and potential events. Additional information about factors that may cause actual results to differ materially from expectations, and about material factors or assumptions applied in making forward-looking statements, may be found in the "Risk Factors" section hereof and elsewhere in the Fund's Management's

Discussion and Analysis of Operating Results and Financial Position ("**MD&A**") for the year ended December 31, 2010 and elsewhere in our filings with Canadian securities regulators. Except as required by Canadian securities law, we do not undertake to update any forward-looking statements, whether written or oral, that may be made from time to time by us or on our behalf. Such statements speak only as of the date made. The forward-looking statements included in this Annual Information Form are, unless otherwise indicated, made as of December 31, 2010 and are expressly qualified in their entirety by this cautionary language.

SUPPLEMENTAL DISCLOSURE

References in this Annual Information Form to "**EBITDA**" are to earnings before interest, taxes, depreciation, amortization, other expenses, goodwill impairment, non-controlling interest, gain/loss on disposal of property and equipment, foreign exchange gains/losses and transaction costs on debt financing. EBITDA is a metric used by many investors to compare companies on the basis of ability to generate cash from operations. EBITDA is not a recognized measure under Canadian generally accepted accounting principles ("**GAAP**") and is not intended to be representative of cash flow or results of operations determined in accordance with GAAP or cash available for distribution. Shareholders are cautioned, however, that EBITDA should not be construed as an alternative to net earnings as determined in accordance with GAAP or to cash flows from operating, investing and financing activities as a measure of liquidity and cash flows, or as an indicator of CML's performance. EBITDA may not be comparable to similarly titled amounts reported by other issuers.

References are also made to "**Distributable Cash**" in this AIF. Distributable Cash is not a GAAP measure, and although it is generally used by Canadian open-ended trusts as an indicator of financial performance, it should not be seen as a measure of liquidity or a substitute for comparable metrics prepared in accordance with GAAP such as cash from operating activities. One characteristic of certain non-GAAP measures such as Distributable Cash is the inclusion of management's adjustments for entity-specific issues not contemplated in a standard measurement, such as "**Standardized Distributable Cash**"[1] that focuses on comparability across entities and consistency over time. Therefore, CML's Distributable Cash may differ from similar calculations as reported by other similar entities and, accordingly, may not be comparable to Distributable Cash as reported by such entities. CML's objective for disclosing the Distributable Cash calculation is to outline the net cash flow generated by CML that was available for distribution during the period and anticipated to be sustainable into the next period. CML uses Distributable Cash to evaluate, on a consistent basis, sustainable cash generated from its operations, and to evaluate cash available for distributions. CML calculates Distributable Cash as:

- Standardized Distributable Cash;
- adding or deducting certain adjustments relating to non-cash working capital items that are known and predictable in nature. CML believes that such adjustments are necessary to provide a more meaningful understanding of sustainable cash flows;
- adding or deducting any notional capital expenditure reserve adjustment determined to be reasonable and necessary for the continuing operation of CML;
- certain adjustments for non-recurring revenues, if applicable, for the period. These adjustments are made by CML to indicate the non-recurring nature of certain transactions that, in CML's view, should not be part of a user's reasonable expectation of the future cash flows; and,
- certain adjustments for discretionary or non-operating expenditures or non-recurring items, funded out of the cash balance available at the beginning of the year and therefore not funded by current period cash flow, if applicable, for the year.

For further detail regarding the Fund's financial information, please see the Fund's financial statements and MD&A for the year ended December 31, 2010, copies of which are available at www.sedar.com.

[1] "**Standardized Distributable Cash**" is defined in these recommendations as the periodic cash flows from operating activities as reported in the GAAP financial statements, including the effects of changes in non-cash working capital, less adjustments for: i) total capital expenditures as reported in the GAAP financial statements; ii) restrictions on distributions arising from compliance with restrictive financial covenants at the date of the calculation of Standardized Distributable Cash; and iii) limitations arising from the existence of a minority interest in a subsidiary. CML's Standardized Distributable Cash reflects its cash flows from operating activities and consequently may be affected by discretionary decisions that defer or advance the timing of those cash flows.

CORPORATE STRUCTURE

Name, Address and Incorporation

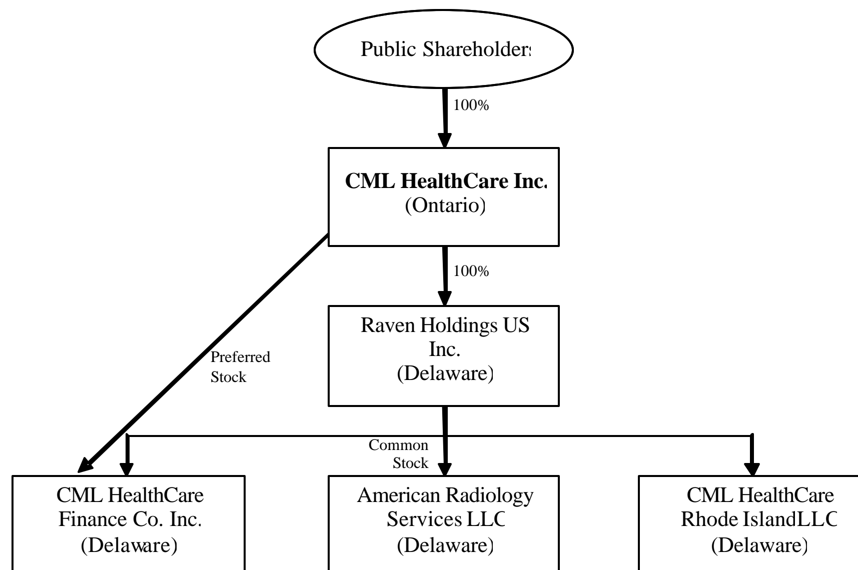
On January 1, 2011, the Fund reorganized its income trust structure into a corporate structure pursuant to a plan of arrangement under the *Business Corporations Act* (Ontario) (the "**Arrangement**"). Under the Arrangement, unitholders of the Fund ultimately received one common share of CML HealthCare Inc. ("CML"), the resulting entity from the amalgamation of CML Healthcare Inc. and 2260408 Ontario Limited completed under the Arrangement, for each trust unit of the Fund exchanged.

As a result of the completion of the Arrangement and related transactions, CML became the successor reporting issuer to the Fund (in each jurisdiction in which the Fund had been a reporting issuer), and now directly and indirectly carries on the businesses previously conducted by the Fund and its subsidiaries. CML's common shares commenced trading on the Toronto Stock Exchange on January 4, 2011 under the symbol "CLC".

CML's head and registered office address is 60 Courtneypark Drive West, Unit #1, Mississauga ON L5W 0B3.

Intercorporate Relationships

The following diagram illustrates the organizational structure of CML (material entities) immediately following the completion of the Arrangement:



History of the Business

Prior to Conversion to Income Fund Structure

Canadian Medical Laboratories Limited, the entity that eventually becomes CML, was founded in 1971 as a single laboratory in Simcoe, Ontario. Over the following 25 years the company grew through organic growth and acquisitions and in 1996 completed an initial public offering.

On October 1, 1997, Canadian Medical Laboratories Limited amalgamated with its wholly-owned subsidiaries Bestview Investments Inc., Bestview Medical Laboratories Limited, Excel Medical Laboratories Ltd., Legalmed Holdings Inc. and Physician's Laboratory Services Ltd.

In 2001, Canadian Medical Laboratories Limited entered the medical imaging business in Canada with the acquisition of DC DiagnosticCare Inc., which operated 146 centres across five provinces (British Columbia, Alberta, Manitoba, Ontario, and Quebec).

On March 27, 2003, Canadian Medical Laboratories Limited filed articles of amendment to change its name to CML Healthcare Inc.

February 23, 2004 to December 31, 2010

On February 23, 2004, CML Healthcare Inc., as it existed at such time, completed a plan of arrangement under the *Business Corporations Act* (Ontario) resulting in the creation of the Fund, a publicly-traded income trust owning all of its diagnostic services business, and Cipher Pharmaceuticals Inc., a publicly-traded corporation owning all of its drug development and pharmaceutical research business. CML Healthcare Inc. ("**Old CML**"), which became a wholly-owned subsidiary of the Fund, was the resulting entity from the amalgamation under the plan of arrangement of CML Healthcare Inc., CML Healthcare Acquisitionco Inc., 1603728 Ontario Inc., 1602928 Ontario Inc. and Diagnostic Acquisition Limited.

Effective June 1, 2006, Old CML amalgamated with CML Healthcare Imaging Inc., LabCare Inc., Cybermedix Health Services Ltd., Fort Frances Clinic Laboratories Limited, 1089998 Ontario Inc. and Diatech Imaging Inc.

On October 2, 2006, Old CML amalgamated with King Street X-Ray Limited, King Street Medical Arts Centre Limited and First Medical Place X-Ray and Ultra-Sound Ltd. On that same date, Old CML also amalgamated with 2111000 Ontario Limited.

On September 1, 2007, Old CML amalgamated with 2145117 Ontario Limited.

On January 1, 2008, Old CML amalgamated with 1469140 Ontario Inc, (doing business as ProMed Echo Ultrasound) and Belex Management Limited.

On January 31, 2008, Old CML acquired Croydon Radiological Services Ltd., and, on April 22, 2008, Old CML acquired Laurel Radiology Inc., both of which are medical imaging operations in the Greater Vancouver area.

On February 29, 2008, Old CML indirectly acquired Maryland-based American Radiology Services, Inc. ("**ARS**") for total consideration of approximately U.S.$150.4 million (inclusive of repayment of term debt of ARS and capital leases assumed), subject to normal post-closing adjustments.

On February 29, 2008, Old CML acquired 1746801 Ontario Inc., operating as "Niagara Falls and Pelham Clinics", and, on July 10, 2008, Old CML acquired Applemed X-ray and Ultrasound Services Inc. Both acquisitions were based in Ontario.

On August 29, 2008, Old CML acquired Alberta-based C.M. Thom and M.L. Irwin Professional Corporation, operating as "Calgary Womens Imaging Centre". On September 19, 2008, Old CML acquired British Columbia-based General Medical Imaging Services Inc.

On January 1, 2009, Old CML amalgamated with 1746801 Ontario Inc., Laurel Radiology Inc., Croydon Radiology Services Ltd. and Calgary Womens Imaging Centre Inc.

On July 31, 2009, Old CML completed the acquisition of substantially all of the assets of Washington Open MRI, Inc. (operating as Quarry Lake Imaging), comprising a medical imaging centre based in Baltimore, Maryland.

On August 10, 2009, Old CML entered into a 50:50 joint venture agreement with Upper Chesapeake Health System to manage a multi-modality imaging centre in Bel Air, Maryland.

On December 17, 2009, Old CML acquired the assets of various diagnostic imaging centers in Rhode Island from The Imaging Institute, Inc. ("**TII**") for total consideration of approximately U.S.$7.7 million, after post closing adjustments (less a working capital adjustment of U.S.$435,000).

On November 18, 2010, through the above-described joint venture with Upper Chesapeake Health System, Old CML acquired the assets of a single site PET/CT operation in Bel Air, Maryland. The cost to Old CML of its 50% interest in the business was approximately U.S.$1 million.

Recent Developments

Organizational Structure

Conversion to Corporate Structure

On January 1, 2011, the Fund reorganized its income trust structure into a corporate structure pursuant to a plan of arrangement under the *Business Corporations Act* (Ontario). See "—Name, Address and Incorporation" above for additional information. See also the Fund's management information circular with respect to the plan of arrangement dated November 1, 2010, which has been filed under the Fund's profile on SEDAR at sedar.com.

Dissolution of CML Healthcare Income Fund

On January 1, 2011, following completion of the Arrangement, the trustees of the Fund took steps to dissolve the Fund pursuant to its declaration of trust. Upon its dissolution, all of the property and liabilities of the Fund were distributed to, or assumed by, CML, and the Fund ceased to exist.

The Fund was delisted from the Toronto Stock Exchange on January 4, 2011 and ceased to be a reporting issuer.

Dividends

On January 1, 2011, grandfathering from the legislative provisions under the *Income Tax Act* (Canada) announced by the Canadian federal government on October 3l, 2006, which imposed a tax at the trust level on distributions of certain income from publicly-traded mutual fund trusts that were previously not subject to income tax under such Act, expired. As a result, the flow-through tax treatment that was a primary advantage of the income trust structure, and which unitholders of the Fund had continued to benefit from during the four-year transition period, was eliminated.

As a corporation, CML's dividend policy is subject to the discretion of its Board of Directors. Future dividends, if any, will depend on the operations and assets of CML and will be subject to various factors, including, without limitation, CML's earnings, financial requirements, the satisfaction of solvency tests imposed by the *Business Corporations Act* (Ontario) for the declaration of dividends and other factors that the directors may deem relevant from time to time. There can be no guarantee that CML will maintain its current dividend level.

CML's post-conversion dividend, anticipated to be $0.0629 per common share per month, reflects a 29.5% decrease from monthly distributions of $0.08927 per trust unit paid to the Fund's unitholders in fiscal 2010. The decrease is an adjustment for the approximate income tax payable by CML effective as of January 1, 2011.

Continued Downward Pressure on Reimbursement Rates in the United States

Healthcare reform legislation was enacted in the United States in the first quarter of 2010 through the passage of two key pieces of legislation: the *Health Care and Education Reconciliation Act of 2010* enacted on March 30, 2010 (the "**U.S. House Reconciliation Act**"), which amended various provisions of the *Patient Protection and Affordable Care Act* enacted on March 23, 2010 (the "**U.S. Patient Protection Act**") (collectively, "**U.S. Health Care Reform Legislation**").

Certain provisions of the U.S. Health Care Reform Legislation, including the following, have the affect of reducing Medicare reimbursement for imaging services. The U.S. Health Care Reform Legislation, currently the subject of a number of court cases challenging its constitutionality and the continued focus of debate among Congress, state governors, and state legislators, is creating uncertainty as to the ultimate financial impact of these reforms. In their current state, such provisions will negatively affect revenues from CML's U.S. operations:

- **Increase in Imaging Equipment Utilization Rate Assumption**: Effective January 1, 2010, the Centers for Medicare and Medicaid Services ("**CMS**") increased the equipment utilization rate assumption that is used to determine the Medicare payment for the technical component of imaging services (such as computed tomography ("**CT**"), magnetic resonance imaging ("**MRI**") and nuclear medicine) that use equipment priced over one million US dollars (as determined by CMS) to 60% (from 50%) under the Medicare physician fee schedule. The U.S. Health Care Reform Legislation further increased the assumed utilization rate to 75% (from 60%), effective January 1, 2011. An increase in the equipment utilization rate reduces the per service cost of performing a test, thereby reducing Medicare payment for imaging services. The utilization rate assumption is a factor in determining reimbursement for the technical component of an imaging service, and the change in assumed utilization rates has resulted in a reduction in Medicare payment for the technical component of advanced diagnostic imaging services.

- **Increase in Multiple Procedure Payment Reduction ("MPPR") Percentage**: Effective for MRI, CT and ultrasound services provided on and after July 1, 2010, the discount that applies to the technical component of additional imaging studies performed on contiguous body parts within the same modality, on a Medicare patient during a single session, was increased to 50% from 25%, which was the discount established in *The Deficit Reduction Act of 2005* ("**DRA**"). The result of this legislation is a reduction in Medicare payment for the technical component of the second and any subsequent imaging services performed on contiguous body parts, within the same modality, on a Medicare patient in a single session.

  In addition to provisions included in U.S. Health Care Reform Legislation, the following recently announced changes to Medicare reimbursement are expected to further reduce revenues from CML's U.S. operations:

- **Bundling of CPT® Codes**: Effective January 1, 2011, the American Medical Association announced new Current Procedural Terminology ("**CPT®**") codes that bundled the single body region codes for CT scans of the abdomen and pelvis into a single combined code when both regions are examined in the same session. In the Medicare Physician Fee Schedule for 2011, CMS assigned Relative Value Units ("**RVUs**") to the professional component and the technical component of these new combination codes for 2011. These new RVUs for the technical component of the new combination codes are approximately 50% lower than the aggregate RVUs assigned to CT scans of the pelvis and abdomen if both scans were performed together in 2010 This coding change and the corresponding Medicare RVU assignment has resulted in a reduction in Medicare payment for the technical component when CT scans of an abdomen and the pelvis are performed on the same Medicare patient during a single session.

- **Reduction in the "Conversion Factor"**: In addition to the reductions described above, the 2011 Medicare Physician Fee Schedule included an across-the-board reduction in the "conversion factor" that is used to calculate the Medicare payment rates. The Medicare conversion factor is a scaling factor that converts the geographically adjusted number of RVUs assigned for each service into a dollar

payment amount. While the U.S. Congress intervened to eliminate a 25% reduction in Medicare payment rates, the conversion factor decreased to U.S.$33.9764 as of January 1, 2011 (from U.S.$36.8729 as of December 31, 2010). This represents a 7.9% reduction in Medicare reimbursement for the professional component and technical component of imaging services in 2011.

Material Contracts and Other Arrangements

Expiry of Funding Agreement for Ontario Laboratory Services

Approximately 50% of CML's fiscal 2010 consolidated revenue came from its Ontario laboratory services business, approximately 85% of which is governed by the terms of a funding agreement between the Ontario Ministry of Health and Long-Term Care ("**MOH**") and the Ontario Association of Medical Laboratories ("**OAML**") that is set to expire on March 31, 2011.

Negotiations for the renewal of the funding agreement between the MOH and the OAML, which represents virtually all of community laboratory service providers, have yet to commence. As negotiations are anticipated to extend beyond the March 31 expiry date, CML will continue to receive funding from the MOH based on the terms of the existing funding agreement. Once a new agreement has been entered into, its new terms will govern and will be retroactive to April 1, 2011. Over the past 10 years, from 2001 to 2011, the compound annual growth rate of the capped funding agreement has been 3.8%. It is unknown what impact, if any, economic pressures facing the MOH will have on funding under the new agreement.

Amendment and Restatement of Credit Agreement

On January 1, 2011, CML amended and restated its existing credit agreement in order to accommodate anticipated changes to its organizational structure and operations resulting from, among other things, the conversion of the Fund to a corporation and the adoption of International Financial Reporting Standards ("**IFRS**") by CML.

Amendment of Long-Term Incentive Plan and Phantom Unit Plan

In connection with the Arrangement, each of CML's long-term incentive plan and phantom unit plan were amended in order to ensure that such plans could continue in effect upon completion of the Arrangement, as well as to reflect CML's post-Arrangement structure. Completion of the Arrangement did not result in an acceleration of the vesting provisions under either of these plans.

On March 3, 2011, the Board of Directors of CML approved one further award under the long-term incentive plan in respect of the 2010 fiscal year; no further awards are currently expected to be made under either of these incentive plans.

Adoption of New Incentive Plans

Following completion of the Arrangement, CML adopted various non-dilutive incentive plans to reflect its post-Arrangement structure, including a deferred share unit plan for its non-employee directors, and a performance share unit plan and a restricted share unit plan for its officers and employees which, among other things, are intended to focus participants on medium-term shareholder returns and to reward and encourage performance.

In addition to the above-mentioned non-dilutive incentive plans, at the special meeting held on December 1, 2010 to consider the Arrangement, unitholders of the Fund approved the adoption of a stock option plan, which authorizes CML to grant rights to purchase common shares to its officers and employees.

Termination of Material Contracts of CML Healthcare Income Fund

In connection with the dissolution of the Fund, each of the following material contracts to which the Fund was a party were terminated:

(a) the declaration of trust dated January 12, 2004, as amended and restated as of February 19, 2004, and as further amended on August 11, 2009 and November 10, 2009, respectively, governing the Fund;

(b) the administration agreement dated as of February 23, 2004 between CML Healthcare Inc. and the Fund; and

(c) the note indenture dated as of February 23, 2004, and restated as of March 26, 2008, between CML Healthcare Inc. and CIBC Mellon Trust Company, as trustee, relating to the unsecured, subordinate notes issued by CML Healthcare Inc. to the Fund.

In addition to the termination of these material contracts, the $807 million aggregate principal amount of interest-bearing notes issued under the note indenture, as well as the non-interest bearing promissory note in the aggregate principal amount of $97 million issued by CML Healthcare Inc. to the Fund, were cancelled.

Termination of Distribution Reinvestment Plan

Effective December 29, 2010, the Fund terminated the distribution reinvestment plan that it implemented on June 2, 2004, pursuant to which Canadian resident unitholders of the Fund were entitled to elect to have cash distributions paid by the Fund reinvested in additional trust units. CML does not currently expect to establish a dividend reinvestment plan.

Financial Reporting

On January 1, 2011, CML adopted IFRS for the preparation and reporting of financial statements and other financial information, which became mandatory in Canada for financial statements of profit-oriented publicly accountable entitles beginning on and after January 1, 2011.

DESCRIPTION OF THE BUSINESS

Business Overview

For 40 years, CML has been providing high-quality diagnostic care. As the largest provider of medical imaging services in Canada, a leading provider of laboratory testing services in Ontario, and a leading provider of medical imaging services in the United States through management services arrangements with contracted radiology practices in Maryland, Rhode Island, and Delaware. CML's network of facilities play a critical role in healthcare delivery.

Management believes CML is one of the three largest providers of community-based laboratory services by revenue in Ontario. CML's laboratory services business has grown from a single medical laboratory established in Simcoe, Ontario, in 1971 to a network of 119 specimen collection centres ("**SCCs**") in urban and rural Ontario. CML holds licences permitting it to perform a broad range of medical tests involving haematology, biochemistry, cytology, microbiology and histology which are used by physicians to diagnose medical conditions, plan or evaluate treatment, and monitor diseases.

CML is a member of the OAML, an industry association representing nine independently-owned laboratories that perform virtually all of the diagnostic testing for patients outside of hospitals. Members of the OAML are under an exclusive, capped funding agreement with the MOH. CML has a 30.6% share of the funding provided under this funding agreement.

CML entered the medical imaging business in Canada in 2001 with the acquisition of DC DiagnosticCare Inc., then Canada's largest medical imaging services company. In 2008, CML entered the U.S. market with the acquisition of Maryland-based ARS. Through subsequent tuck-in acquisitions, CML currently operates Canada's largest network of community-based medical imaging centres comprised of 108 locations with 77 in Ontario, 19 in British Columbia, nine in Alberta, two in Manitoba and one in Québec. In the U.S., CML manages 17 facilities in Maryland, five in Rhode Island and one in Delaware.

CML holds licences in Canada to perform, and holds licenses in the U.S. to the extent required to own equipment and manage its contracted radiology practices that perform a broad range of medical imaging procedures including ultrasound, x-ray, bone densitometry, mammography, fluoroscopy, MRI, nuclear medicine, CT, and PET/CT scans. Among the high-end modalities, CML has two MRI units in British Columbia; one in Alberta; two MRI units and two CT units in Ontario; 21 MRI, 17 CT and eight PET/CT in Maryland; four MRI and three CT in Rhode Island; and one MRI unit and one CT unit in Delaware. In the U.S., in addition to its free-standing medical imaging facilities, ARS also provides management services with respect to radiology services being provided to 10 hospitals in Maryland, as well as with respect to remote reading services being provided via teleradiology to 22 hospitals across five states and the District of Columbia.

For the year ended December 31, 2010, CML's revenues and EBITDA were $480.4 million and $125.1 million, respectively, compared to $518.5 million and $140.1 million respectively, for the year ended December 31, 2009. The lower revenue in fiscal 2010 reflects accounting for the new Management Service Agreement in Maryland, which had the effect of reducing revenues and offsetting costs by approximately $27.8 million compared to 2009. Changes in foreign exchange rates also contributed to lower revenues.

Industry Overview

Healthcare Industry

Canada

The healthcare payment system in Canada may be described as an interconnected set of ten provincial and three territorial healthcare insurance plans. The management and delivery of healthcare services is the responsibility of each individual province or territory. The federal government's role in healthcare involves setting and administering national principles for the system, as well as assisting in the financing of the healthcare services, delivered by the provinces and territories through transfer payments. The *Canada Health Act* endeavours to ensure that the health care insurance plan of each province and territory insures all medically necessary services provided by, primarily, hospitals and physicians, except that the Canada Health Act does not apply to services pursuant to Act of Parliament or the legislature of a province or territory relating to workers' or workmen's compensation.

According to the Canadian Institute for Health Information, Canada's total healthcare expenditures were forecasted to have reached $191.6 billion in 2010, an estimated increase of $8.5 billion, or 4.6%, over 2009. These forecasted expenditures represent approximately 11.7% of Canada's gross domestic product. Of this amount, approximately 65.3% was forecasted to have come from Canadian provincial and territorial governments, with the remaining expenditures coming from the federal government, municipal governments, social security funds, and private sources, including private health insurance and user-pay sources. Although health spending in 2010 continued to increase, the estimated increase in healthcare spending from 2009 to 2010 was the smallest observed since 1997.

In most instances, community-based (as opposed to government-owned and/or operated) providers of healthcare services, such as CML, are paid on a fee-for-service basis, subject to the "cap" described below for certain laboratory services. The fees are established through negotiation on a province by province (or territory by territory) basis between the applicable provincial (or territorial) health ministry and various stakeholder groups.

United States

The National Coalition on Health Care in the United States reported that, in 2009, healthcare spending in the U.S. reached U.S.$2.5 trillion and is projected to reach U.S.$4.4 trillion by 2018. This growth reflects the combined impact of demographic and technological drivers. Medical imaging expenditures in the U.S. are estimated at approximately U.S.$100 billion. Management estimates that out-patient medical imaging in the United States is a U.S.$40 billion market.

Healthcare services in the United States are largely paid for by a combination of public and private payers. A significant percentage of the U.S. population has access to some level of health insurance, which includes both publicly-funded health insurance plans and private health insurance plans.

Diagnostic Services Industry

Diagnostic services are a vital part of the healthcare system. These services, which include laboratory services, imaging services, stress testing, electrocardiograms and hearing testing, facilitate effective, efficient diagnosis, monitoring, and in many cases preventative treatment of medical conditions.

Laboratory Services

Laboratory testing is generally categorized as either clinical testing, which is performed on bodily specimens including blood and urine, or anatomical pathology testing which is performed on cytological specimens, tissue, and other samples, including human cells. Licenced medical diagnostic laboratories generally perform tests on bodily specimens and tissues for the purpose of diagnosing medical conditions and screening for evidence of specific drug use. Examples of frequently performed tests include blood chemistry analysis, urinalysis, haematology, PAP smears, microbiology, screening for the HIV virus or for the presence of drugs or alcohol.

Publicly-funded laboratory testing services across Canada are provided by public service providers. In Ontario, British Columbia, Alberta, Manitoba, Saskatchewan and, to a limited extent, Quebec, laboratory services are also provided by community-based service providers. Management of CML estimates that, Canada-wide, greater than 50% of laboratory testing is performed by public health and hospital-based laboratories, the balance being provided by community-based laboratories. In Ontario, substantially all out-patient laboratory services are provided by community-based laboratories on a fee-for-service basis subject to a negotiated maximum annual aggregate payment (known as a “cap”), and substantially all in-patient laboratory services are provided by hospitals.

In Ontario, there are four types of medical diagnostic laboratories: public health laboratories, hospital laboratories, community-based laboratories and physician-operated laboratories. The public health laboratories have generally concentrated on epidemiological matters, such as the tracking of the spread of HIV; hospital laboratories have concentrated on the laboratory needs of the hospital’s patients; the community-based laboratories have concentrated on the patients of private physicians; and the physician-operated laboratories offer a very limited range of testing services, available only for that physician’s patients.

Facilities operated by community-based laboratories include: (i) SCCs, where specimens are taken at the request of the referring physician but where no tests are carried out; (ii) local or regional laboratories to which specimens from SCCs and other collection points are sent for testing; and (iii) central laboratories where high-volume, multi-channel equipment perform various tests on a single specimen and where specialized tests are carried out.

For the fiscal year of the MOH ended March 31, 2010, there were approximately 18.4 million requisitions (patient visits) to community-based laboratories in Ontario, resulting in a total of approximately 121.2 million tests performed on patients for an average of 6.6 tests per requisition or patient visit and 9.2 tests per capita (per person in Ontario). The table below shows the growth in demand for laboratory services in Ontario over the last five years:

	MOH Fiscal Year Ended March 31,				
	2006	**2007**	**2008**	**2009**	**2010**
Population estimates (in millions)	12.7	12.8	12.9	13.1	13.2
Number of tests (in millions)	97.6	99.6	105.3	116.7	121.2
Number of requisitions (patient visits) (in millions)	17.0	17.1	17.2	17.5	18.4
Tests per requisition	5.7	5.8	6.1	6.7	6.6
Tests per capita	7.7	7.8	8.2	9.0	9.2

Source: OAML; Statistics Canada

Medical imaging procedures use energy waves to penetrate human tissue and generate images of the body that can be recorded on film or digitized for display on a video monitor and used to diagnose diseases and physical injuries.

Medical imaging services are typically provided in the following settings:

- *Hospital Setting*. Medical imaging systems are located in and owned and/or operated by a hospital or a hospital out-patient clinic.

- *Freestanding Fixed Site Imaging Centres*. Medical imaging systems are located in dedicated freestanding facilities owned and/or operated by entities that are not affiliated with hospitals or physician practices.

- *Physician Setting*. Medical imaging systems are located in and owned and/or operated by a physician or physician groups.

- *Mobile Imaging*. Medical imaging systems are located in mobile trailers that are owned and/or operated by entities that are typically not affiliated with, or owned and/or operated by, hospitals or physician practices.

- *Teleradiology*: Teleradiology is the transmission of patient images, such as x-rays, CTs and MRIs via a network for the purpose of interpretation by a radiologist who is based at a different location. Currently teleradiology is used frequently in rural areas to obtain a sub-specialty radiologist opinion located in another community, or to provide off-hour reading services for hospitals or large physician practices or imaging centres.

Common imaging modalities include the following:

- *X-Ray and Fluoroscopy*. X-rays penetrate the body and record images of organs and structures on film or digitally. Fluoroscopy utilizes x-rays combined with a video-viewing system for real time monitoring of organs.

- *Ultrasound*. Ultrasound imaging utilizes high-frequency sound waves to acquire images of internal organs, embryos and the muscular, skeletal, and vascular systems. Ultrasound has widespread applications, particularly for procedures in obstetrics, gynaecology, general body imaging and cardiology.

- *Mammography*. Mammography is a specialized form of radiology utilizing low dosage x-rays to visualize breast tissue and is the primary screening tool for detection of breast cancer.

- *Bone Densitometry*. Bone densitometry is a quick, simple and painless examination that is currently the most sensitive screening tool used to detect bone loss in early stages of osteoporosis. It is also the least expensive and most cost-effective method for this type of examination.

- *Nuclear Medicine*. Nuclear medicine utilizes short-lived radioactive isotopes which release small amounts of radiation that can be recorded by a gamma camera and processed by a computer to produce an image of various anatomical structures or to assess the function of various organs such as the heart, kidneys, thyroid and bones. Nuclear medicine is used primarily to study anatomic and metabolic functions.

In addition to the imaging modalities described above, other, more advanced, imaging modalities are available and include the following:

- *Computed Tomography ("**CT**")*. CT utilizes a computer to direct the movement of an x-ray tube to produce multiple cross-sectional images of a particular organ or area of the body. CT is used to detect tumours and other conditions affecting bones and internal organs. It is also used to detect the occurrence of strokes, haemorrhages and infections. CT has the benefit of providing images in the axial, coronal and sagital planes.

- *Magnetic Resonance Imaging ("**MRI**")*. MRI utilizes a strong magnetic field in conjunction with low energy electromagnetic waves, which are processed by a computer to produce high-resolution images

of body tissue including the brain, spine, abdomen, heart and extremities. Unlike CT and conventional x-rays, MRI does not utilize ionizing radiation.

- *Positron Emission Tomography ("**PET**")*. PET is a nuclear medicine procedure that produces images of the body's metabolic and biological functions. PET utilizes a scanner to record signals emitted by compounds with signal-emitting tracers after these compounds are injected into a patient's body. A scanner records the signals as they travel through the body and collect in the various organs targeted for examination. PET provides detection and tracking of cancers (including lung, colorectal, breast and prostate cancers), coronary disease and neurological problems (including Alzheimer's disease, Parkinson's disease and seizure disorders).

The number of procedures performed at a medical imaging centre is a key driver of its financial success. Physicians will refer patients to an imaging centre based on a number of factors, including prior relationships, the accuracy and timeliness of diagnostic reports, interaction with radiologists, technology, patient satisfaction, and customer service. Patient satisfaction, in turn, is dependent on a number of factors, including accuracy, the geographical availability of the imaging centre, the care delivered by the centre staff, the prompt administration of the diagnostic test, and the condition of the centre and equipment. Diagnostic imaging centres are usually located near doctors' offices and are generally accessible by public transit.

In addition to referrals from physicians, an imaging centre can generate referrals from third-party payors such as workers' compensation boards, insurance companies, and corporate employers. Additional sources of referrals include the legal profession in connection with injury litigation, the chiropractic profession, sports medicine professionals, and certain federal government departments that require imaging services for their employees on a national basis.

Industry Trends

Management expects that the following factors will continue to drive increased demand for diagnostic services:

- general aging of the population;

- greater insurance coverage

- increased focus on preventative medicine;

- wider awareness and acceptance by healthcare providers and patients of the benefits from the use of diagnostic testing in the screening, diagnosis, treatment and prevention of disease; and

- technological and scientific advancements and improvements resulting in expanded uses for current technology and the development of more sophisticated and specialized diagnostic testing equipment, tests, and procedures.

Strengths and Strategies

Strengths

Management believes CML has the following operational strengths which can be applied to achieving its strategy of sustaining and, where possible, increasing the amount of cash available to pay dividends to shareholders:

- *Full Complement of Licences to Perform Diagnostic Services*. CML holds licences to perform a broad range of laboratory tests in Ontario and medical imaging procedures in all markets in which it operates. Since the various governments do not readily or frequently issue licences for laboratory testing or medical imaging procedures, CML management believes this could act as a significant barrier to entry.

- *Established Relationships.* A key factor in generating volume growth in diagnostic medical services is having established relationships with various stakeholders. CML has the benefit of having long-term

relationships with referring physicians, and other healthcare providers, hospitals, and payors. Through its trained professional business development personnel and operations managers, CML continues to seek ways to provide stakeholders with value-added services such as continuing medical education seminars and information technology support in order to strengthen relationships and seek referrals for diagnostic services from healthcare providers.

- *Large Developed Networks.* CML is one of three laboratory services providers in Ontario that account for approximately 95% of all diagnostic testing procedures for non-hospital patients. CML operates an Ontario-wide laboratory network with one central laboratory and 119 SCCs. CML also operates Canada's largest medical imaging network comprised of 108 centres, with 77 locations in Ontario, 19 in British Columbia, nine in Alberta, two in Manitoba, and one in Quebec. In the U.S. northeast, CML has a strong presence with 17 centers in Maryland, five in Rhode Island, and one in Delaware. CML believes that its size and scale provides it with the leverage necessary to gain economies of scale with vendors. As well, since CML is the only diagnostic services provider with licences to provide both laboratory as well as imaging services in Ontario, CML is able to cross- market its services to referring physicians. In the past two years, CML has developed several new locations in which both laboratory and imaging services are offered at the same location, providing convenience and quality care for CML patients, and greater efficiency for CML.

- *Technological and Operational Leadership.* CML employs high-quality, advanced technology to operate its businesses effectively and efficiently. CML's central Mississauga, Ontario laboratory is equipped with highly-automated instrumentation and is currently undergoing a significant reconfiguration designed to improve workflow and efficiency. Although CML already has a low-cost operating structure, it is continually seeking further cost efficiencies through the use of technology. In addition, management believes the CML's operational expertise from managing the business for over 40 years can be applied to its most recent medical imaging acquisitions to realize further growth and operational efficiencies.

- *Experienced Employees.* CML employs approximately 2,200 full-time and 1,300 part-time employees across Canada and the U.S. CML must be able to recruit and retain skilled and qualified staff in order to be able to deliver on its commitment of providing quality care to patients. Over the past two years, CML has made great advances in improving its work environment through initiatives such as a refurbishment program; an investment in digitization and advanced technologies; focus on a patient-centered culture; and training and employee communication programs to enable career development.

Strategy

CML's strategy of sustaining, and where possible, increasing, the amount of cash available to pay dividends to shareholders involves a continuing commitment to delivering the highest level of service to patients and healthcare providers while offering value for money to its payors. CML intends to continue to focus on the following initiatives in order to fulfill the various competing needs of each of its stakeholders - investors, patients, healthcare providers, employees, and payors:

- *Enhance Patient Experience.* CML intends to continue to introduce patient-focused initiatives that increase ease of use and enhance the overall patient experience. Over the past two years, CML has introduced a rebranding and refurbishment program for its Canadian facilities, designed to lessen patient anxiety and to achieve a consistent brand across its various locations. CML has also introduced a new, updated website, which includes an interactive centre locator (allowing patients to easily locate the nearest CML centre), on-line booking capability, and a health information library (allowing patients to learn more about an upcoming medical imaging procedure or laboratory test).

- *Expand and Enhance Relationships with Healthcare Providers.* CML intends to continue to introduce initiatives that enhance the overall experience of healthcare providers. Over the past two years, CML has significantly expanded the scope of information offered to healthcare providers, including continuing medical education seminars on key, timely topics of interest to referring physicians, and has introduced an expanded testing menu and upgrades to its advanced information technology systems,

providing physicians with improved diagnostic capabilities that allow for better patient care. CML is also in the process of developing a secure, web-based portal, which will allow referring physicians to access test results remotely. In addition, CML intends to further focus on expanding its relationships with referring physicians, especially in Ontario where management believes there is significant opportunity to leverage its large referral network for laboratory services to market its imaging services, and vice versa.

- *Expand Diagnostic Scope*. CML intends to continue to focus on initiatives that ensure it remains well-positioned to offer choice and diagnostic solutions to healthcare providers and patients. CML regularly evaluates the latest advances in medical testing methods to take advantage of new technologies that provide more accurate diagnoses and results, and offer value for money to its payors. Over the past two years, CML has introduced a number of new medical tests, including digital mammography, which, among other things, has been shown to have an advantage in the early detection of breast cancer as well as potentially reducing exposure to radiation as a result of the reduced need for additional images, and the most sensitive test currently available for the detection of human pappilloma virus.

- *Optimize Operating Efficiencies*. CML intends to continue to take advantage of opportunities to increase operating efficiencies and operating performance, including creating combination facilities that offer both laboratory and imaging services, consolidating, relocating, or divesting under-performing centres, and implementing advanced information technology systems.

- *Focus on Profitable Contracting*. Management believes its position as the leading provider of diagnostic imaging services in Canada and one of the leading providers of laboratory services in Ontario enables it to obtain relatively more favourable contract terms than would be available to smaller, less experienced providers. CML intends to continue to regularly evaluate its contracts with payors, industry vendors, radiology groups, as well as its equipment and real property leases, to determine how it may improve the terms in order to improve operating results.

- *Expand Network*. CML intends to continue to evaluate opportunities to expand its network, and may selectively pursue acquisitions or develop greenfield centres that are expected to be accretive to Distributable Cash where, among other considerations: the regulatory environment permits; there is sufficient patient demand for outpatient diagnostic services; there is an opportunity to gain market share; payors are receptive to CML's entry into the market; and CML has adequate financial resources to expand. In addition, management believes demand for MRI and other advanced imaging modalities will continue to increase as physician and patient awareness of their benefits increases. Emerging, advanced imaging modalities, such as PET, may also provide opportunities for growth, particularly in Canada where its use is currently more limited.

Laboratory Services Business

Overview

CML's laboratory services business has grown from a single medical laboratory established in Simcoe, Ontario, in 1971 to a network of 119 SCCs in urban and rural Ontario. In addition to its licenced SCCs, CML maintains a number of centrally located "drop-off" centres where specimens are picked up and sent to nearby SCCs via an extensive courier network that provides scheduled and immediate request pick-up services in most regions of the province. Specimens collected at the SCCs are prepared for testing and entered into CML's information systems prior to being sent to CML's central laboratory in Mississauga, Ontario for analysis. Results are reported on a timely basis to the referring physicians electronically.

CML's central laboratory is a 55,000 square foot facility, licensed to perform approximately 180 types of tests, representing the majority of all tests ordered by physicians in Ontario. Operating 24 hours per day, seven days per week, the central laboratory typically processes specimens from 19,000 to 22,000 patients daily, with an average of 6.6 tests per specimen.

CML holds licences permitting it to perform a broad range of medical tests involving haematology, biochemistry, cytology, microbiology, and histology which are used by physicians to diagnose medical conditions, plan or evaluate treatment, and monitor diseases, including drug screening and surgical pathology as well as supporting diagnostic procedures such as electrocardiograms, holter monitoring and pulmonary function tests. In addition, CML provides laboratory testing services for industrial applications, employee testing and evaluation assessment, and works with company physicians to perform on-site testing that are specific to the work environment.

CML is a member of the OAML, an industry association representing nine independently-owned laboratories that perform over 95% of all diagnostic testing for patients outside of hospitals. Members of the OAML are under an exclusive, capped funding agreement with the MOH based on market shares of the respective members in 1998. With approximately 30.6% of the capped funding from the MOH, approximately 85% of CML's laboratory testing revenue comes from a stable, contracted revenue stream, while the balance comes from fee-for-service laboratory tests.

CML capitalizes on economies of scale not available to smaller laboratories, allowing CML to effectively manage its costs through efficient use of labour, material, overhead costs, equipment and technology, and through efficiencies in its specimen collection network.

One of CML's principal assets is its long-term relationships with physicians, and other healthcare providers who provide referrals for laboratory services. As the great majority of both laboratory and medical imaging services are performed at the direction of referring physicians, one of the more important aspects of CML's marketing strategy is to build on the timeliness and accuracy of reporting results that physicians expect, by ensuring the continued development of a comprehensive physician referral network. CML markets its services to referring physicians through visits to their offices by its regional operations managers who have a high degree of technical expertise in the laboratory services industry allowing them to provide physicians with detailed information about the current testing services provided by CML, along with new innovations in testing and related technological advancements.

Facilities

Each of CML's SCCs is currently leased. The leases are on terms that are customary in the industry. The majority of these leases contain exclusivity clauses that ensure CML will be the only SCC in any given building in which it has leased premises. No one lease for a SCC is material to CML's business. The current terms of these leases are scheduled to expire, subject to rights of renewal, as follows:

Calendar Year	No. of Leases
2011	20
2012	21
2013 or later	37
Month to Month Tenancy	41
	119

CML's central laboratory is subject to a lease expiring May 31, 2015, with an option to renew for two five-year terms.

Information Systems and Results Reporting

Specimen testing and reporting is highly automated through the use of a computer system that tracks specimens from the collection sites and throughout the testing stages to ensure timely reporting of results. CML continues to invest in automation, including high volume analyzers that increase testing capacity and efficiency, thereby increasing operating margins.

CML employs electronic data transmission systems that allow test results to be directly transmitted to medical office systems, typically within 24 hours of specimen collection. CML's computer systems are also used to provide billing information to health insurance plans. Additionally, CML has a website that enables physicians to access laboratory results and perform medical literature searches.

Revenues

In Ontario, the fees for testing services rendered by community-based laboratories, such as CML, are primarily paid by the health insurance program of the MOH. Substantially all of the revenues of CML's laboratory services are received from this health insurance program. Fee levels are set through negotiations between the MOH and OAML, a representative body for the community-based medical laboratories in Ontario of which CML is a member. The MOH has adopted various measures to manage diagnostic utilization to control and limit fees paid under the program, including the implementation of the "industry cap" and the "corporate cap" as described below.

The majority of revenues paid by the MOH to providers of laboratory services, including CML, are subject to an industry and a company maximum limit on aggregate billings, commonly referred to as the "industry cap" and the "corporate cap", respectively.

On December 15, 2008, the OAML entered into a three year funding agreement with the MOH. Under terms of the MOH funding agreement, which was retroactive to April 1, 2008, the MOH increased the provincial payment base cap for laboratory services to OAML members from $610.1 million for the year ended March 31, 2008 to $649.3 million for the year ending March 31, 2011. Including additional funding allocated for meeting certain utilization thresholds, industry compensation increased from $610.1 million for the year ended March 31, 2008 to $655.2 million.

It is anticipated that sometime in 2011, the OAML and MOH will begin negotiations for a new funding agreement. Any change in the provincial payment cap from the cap in effect for the year ending March 31, 2011 will depend on such factors as MOH-directed programs, changes in utilization, and prevailing economic conditions. CML, which currently holds approximately 30.6% of the provincial industry cap, will receive its proportional share from the MOH.

Regulation

In Ontario, medical laboratories must be licenced by the MOH. There are currently two forms of licence that have been granted to CML by the MOH: a laboratory licence, and a SCC licence. The licencing and regulatory requirements relate to, among other matters, conduct of testing and reporting of results; the handling and disposal of medical specimens, infectious and hazardous waste, and other materials; the safety and health of laboratory employees, and the proficiency of staff. A licence can be revoked if prescribed standards are not met. To date, CML has never had a licence revoked.

No new community-based laboratory licences have been issued since the first licences were issued in 1974, and these licences are accordingly of significant value. The restriction on licensing constitutes a barrier to entry and, together with a funding model based on industry caps and individual corporate caps, a barrier to expansion within the community-based laboratory business in Ontario through any means other than the acquisition of existing licenced businesses. CML's community-based laboratories hold licences with a full range of permitted tests, allowing CML to perform the majority of tests referred by physicians.

Laboratory licences authorize medical diagnostic laboratories to perform specific tests, which vary from licence to licence. Laboratory licences are issued for terms of up to five years and are routinely renewed, subject to government approval. Laboratory licences may not be transferred (to other persons or other locations) without the approval of the MOH. Licencees are subject to spot audits conducted by the Ontario Medical Association (the "**OMA**") and also spot audits by the MOH.

Specimen collection licences authorize the collection of specimens, which are then sent to a licenced laboratory for analysis. Subject to the approval of the MOH, licencees have the ability to transfer SCC licences from one location to another.

Environmental matters including use, storage, handling, discharge, transportation, and disposal of hazardous materials (including biomedical and pathological waste, infectious product, chemical and radioactive materials) are strictly regulated. The Province of Ontario plays a key role in regulating and issuing licences and registrations for operations within the province (such as air and water effluent discharges and waste management) and federal regulators also have jurisdiction, particularly in regard to transportation of dangerous goods (chemicals or infectious materials, for example), over certain defined toxic substances and radioactive substances. Penalties for infractions of environmental regulations have been steadily increasing in Canada in recent years, and emission, discharge, and licencing standards have become increasingly stringent.

All community-based laboratories in Ontario are also subject to provincial regulation in respect of occupational health and safety. Laboratory workers are subject to the Healthcare and Residential Facilities Regulation made under the *Occupational Health and Safety Act* (Ontario) which provides for extensive requirements relating to workplace safety for healthcare employers, including clinical laboratories, whose workers may be exposed to blood-borne pathogens such as HIV and Hepatitis B virus. This regulation, among other things, requires work practice controls, protective clothing and equipment, training, voluntary medical surveillance and other measures designed to minimize exposure to, and transmission of, blood-borne pathogens.

CML is also subject to the requirements under the *Personal Health Information Protection Act, 2009* (Ontario) ("**PHIPA**"). CML's relevant policies have been created (or amended), documented and implemented as required under PHIPA.

Quality Control

CML maintains extensive quality control programs in all of its laboratory locations. Although the scope of the program depends to some extent on the particular licence in effect at a particular location, the following quality control measures generally apply: (i) mandatory participation in the External Quality Assessment surveys operated by the OMA for the MOH for all laboratory disciplines, and administered by Quality Management Program-Laboratory Services (the "**QMP-LS**"), under which CML performs tests on samples distributed by the QMP-LS and results are evaluated for comparison with other laboratories to ensure that test results are within prescribed guidelines; (ii) voluntary participation in the worldwide Randox International Quality Assessment Scheme ("**RIQAS**") Quality Control Program, a program by which CML is compared with 1,500 other laboratories around the world on the basis of accuracy in the area of biochemistry; (iii) Urinary Proficiency Study Program for Urinalysis; and (iv) various internal quality control measures for all disciplines to ensure that the accuracy and precision of test results are within accepted standards of performance. CML is fully compliant with all quality control and regulatory requirements.

To assist in the development of new laboratory diagnostic tests and testing methods, CML has established a network of laboratory physicians throughout Ontario, each of whom is an expert in their particular specialty. These physicians assist in evaluating new tests and test methods. In addition, at the request of CML, a physician may be requested to monitor service levels to ensure that physicians' and patients' expectations and needs are fulfilled.

Employees

As at December 31, 2010, CML employed 787 full-time and 476 part-time employees in its laboratory services business, approximately 11% of whom were unionized as further described in the table below. CML's management considers its relationship with its unionized employees continues to be constructive.

Employee Group	Location	Employees	Union	Agreement Expiry Date
SCC employees	Greater Toronto Area, Ontario	22	OPSEU Local 544	December 31, 2012
SCC employees	Greater Toronto Area, Ontario	113	SEIU Local 2	January 31, 2011*

** The contract with SEIU Local 2 is currently being negotiated. Existing contract agreement continues to be in effect.*

Competition

CML's major competitors in the community-based laboratory services sector in Ontario are LifeLabs and Gamma-Dynacare Medical Laboratories. Currently, CML is one of the three largest community-based laboratories with SCCs located throughout Ontario. A number of smaller laboratories, often regional, collectively service less than 10% of the market. There are a number of barriers to entry into the laboratory services sector in Ontario, including the corporate cap system under the MOH, the limited number of provincial government licences, the limited number of high volume SCC locations, and the increased competition from the larger laboratory service providers resulting from the continuing trend of consolidation of the industry.

Seasonality

CML's revenue and EBITDA from its laboratory services business is not generally subject to significant quarterly seasonality.

Potential Growth

Historically, in the absence of acquisitions, organic revenue growth has been driven by the increasing demand for laboratory services which resulted in the expansion of the industry cap and CML's individual corporate cap under agreements negotiated between the MOH and the OAML. CML intends to pursue additional organic growth by (i) seeking to expand its testing menu as new tests, including genetic testing, are developed and seeking additional compensation for these tests where justified; (ii) offering new diagnostic services; and (iii) continuing to seek additional operational efficiencies by leveraging its information technology and logistics expertise. In addition, CML may selectively pursue acquisitions of other laboratory services businesses in Canada where the acquisitions are expected to be accretive to Distributable Cash.

Imaging Services Business

Overview

CML entered the medical imaging business in Canada in 2001 with the acquisition of DC DiagnosticCare Inc., then Canada's largest medical imaging services company. CML currently operates Canada's largest network of community-based medical imaging centres comprised of 108 locations with 77 in Ontario, 19 in British Columbia, nine in Alberta, two in Manitoba, and one in Quebec.

CML manages medical imaging centres in the U.S. through ARS and CML HealthCare Rhode Island LLC ("**CML RI**"), which are owned by Raven Holdings U.S. Inc. ("**Raven Holdings**"), a subsidiary of CML.

- ARS is based in Baltimore, Maryland and manages 17 fixed site imaging centres in Maryland and one in Delaware, three of which are joint ventures with local hospitals.
- CML RI manages five fixed site imaging centres in Rhode Island.

CML holds licences in Canada to perform, and holds licenses in the U.S., to the extent required to own equipment and manage its contracted radiology practices that perform, a broad range of medical imaging procedures including ultrasound, x-ray, bone densitometry, mammography, fluoroscopy, MRI, nuclear medicine, CT, and PET/CT scans. Among the high-end modalities, CML has two MRI units in British Columbia; one in Alberta; two MRI units and two CT units in Ontario; 21 MRI, 17 CT and seven PET/CT in Maryland; four MRI and three CT in Rhode Island; and one MRI unit and one CT unit in Delaware. In the U.S., in addition to its free-standing medical imaging facilities, ARS also provides management services with respect to radiology services being provided to 10 hospitals in Maryland, as well as with respect to remote reading services being provided via teleradiology to 22 hospitals across five states and the District of Columbia.

CML's contracted radiologists are required to read and provide a report on each medical imaging exam. The turn-around time and quality of the diagnostic reports are important to referring physicians while the accessibility of the centre for the patient is key to patient satisfaction. Reports are typically returned to referring physicians within 24 to

48 hours. CML's medical imaging centres are typically located near hospitals and doctors' offices and are generally accessible by public transportation.

CML is committed to maintaining high quality medical imaging equipment in all modalities for which it supplies diagnostic services. CML purchases or leases its medical imaging equipment and, through a combination of in-house and outsourced servicing, is capable of maintaining and ensuring maximum performance from its medical imaging equipment. CML works with suppliers to continue training programs for its in-house service personnel on a regular basis. Due to its size, CML maintains its own in-house capabilities in certain jurisdictions and realizes substantial savings on services otherwise provided by manufacturers or other outside maintenance service providers.

CML has an ongoing capital replacement program to ensure its medical imaging equipment is updated and operating efficiently and effectively.

Revenues

Canada

The revenue generated by an imaging centre is derived primarily through reimbursement by the provincial healthcare system in the province in which the centre operates, paid directly to CML on a fee-for-service basis. The fee includes a technical fee to cover the capital costs of the equipment and expenses, such as labour and consumables, and a professional component which covers the costs of a radiologist who is paid by the imaging centre to read the imaging procedures.

Currently, CML has two MRI centres in British Columbia and one MRI centre in Alberta that operate outside of the provincial healthcare system. Services provided by these three centres are not paid for through a government funded system, but generate revenue on a patient-pay basis.

United States

Healthcare services in the United States are largely paid for by a combination of public and private payors. A significant percentage of the U.S. population has access to some level of health insurance, which includes both publicly-funded health insurance plans and private health insurance plans.

Public and private insurance plans cover a portion of the cost of healthcare services. Generally, private insurance patients and/or their employers pay a premium for healthcare coverage plus 100% of the cost of healthcare services until an initial deductible is reached. The amount of the deductible varies depending on the type-of insurance plan, among other factors. After the deductible is reached, the insurance plan covers a portion of the cost of a patient's healthcare services and generally requires a co-insurance payment to be paid by or on behalf of the patient or the patient's secondary insurance carrier. These co-pay or co-insurance payments typically represent a relatively small portion of the overall cost of the healthcare services.

Medicare/Medicaid

Medicare is the federal health insurance program for people age 65 or older and certain disabled people under age 65. Services billed to Medicare, indirectly through participating radiology groups, are reimbursed on the basis of rates set forth in the Medicare Physician Fee Schedule. Medicare patients usually pay a 20% co-insurance payment unless they have secondary insurance. Medicaid rates are set by the individual states.

Commercial Insurance

Private health insurance in the United States is dominated by third-party payor coverage generally obtained through the workplace. These plans typically provide comprehensive healthcare coverage to insured enrolees and offer financial incentives for patients to use healthcare providers associated with such plans.

Services billed to insurance companies, through participating radiology groups, are reimbursed on the basis of agreed upon rates. The patients are not responsible for any amount above the insurance allowable amount.

Quality Control

Canada

All CML medical imaging centres are required to adhere to stringent documented Imaging Quality Control and Assurance procedures established and maintained by several regulatory groups such as the Independent Health Facilities of the MOH, X-Ray Inspection, Diagnostic Accreditation Program in British Columbia, and the various provincial College of Physicians and Surgeons.

The respective provincial Colleges of Physicians and Surgeons or its designate conduct regular assessments of the quality of services provided, including patient care, diagnostic accuracy and patient and staff safety.

United States

For discussion relating to U.S. quality control, see "Regulation — United States" below.

Regulation

Canada

Medical imaging centres are regulated by the health ministry of the province in which they are located. Other than in Alberta, a centre cannot operate within the provincial healthcare system and bill for insured services without a licence. The licence also provides for the modalities which can operate in the particular location.

In Ontario, very few new licences for new medical imaging centres have been granted since 2003, creating a significant barrier to entry into the medical imaging sector. In some cases, new licences for existing medical imaging centres have been expanded to permit the centres to provide additional medical imaging modalities. In 2003, the Ontario government granted licences for seven new community-based medical imaging centres providing MRI and/or CT services. Medical imaging licences in Ontario may generally be transferred when medical imaging centres are sold, and there is a limited ability to relocate existing medical imaging centres within given catchment areas. Similarly, licences and accreditation for the operation of medical imaging centres in British Columbia (other than provincial payor general imaging licences) and Quebec are not readily available. Alberta does not have a restricted licence program but does have rigorous accreditation requirements for the establishment of medical imaging centres.

United States

ARS and CML RI, and the radiology practices they manage, are subject to extensive regulation by both the U.S. federal government as well as the individual states in which the companies operate. The following is a brief discussion of some of the principal areas of regulation to which CML's business in the United States is subject.

Fraud and Abuse

U.S. federal statutes intended to guard against fraud and abuse in federal healthcare programs, such as Medicare and Medicaid, require careful structuring of business arrangements involving imaging services. The most relevant of these statutes are the Federal Physician Self-Referral Law (the "**Stark Law**") and the Federal Anti-Kickback Statute (the "**Anti-Kickback Statute**"). The Stark Law restricts the ability of physicians to refer beneficiaries of federal and state healthcare insurance programs for designated health services (including imaging services) to entities in which the physicians or their immediate family members have financial relationships. The Anti-Kickback Statute prohibits knowingly and wilfully paying remuneration to any person to induce the person to purchase, prescribe, recommend, or refer a person for the furnishing of items and services payable under a federal healthcare program. Violations of the Stark Law may result in denial of payment, recoupments, civil money penalties, and exclusion from the Medicare program. Violations of the Anti-Kickback Statute may result in civil or criminal penalties and exclusion from federal healthcare programs. While courts have permitted federal *False Claims Act* lawsuits premised on alleged Stark Law, courts have not consistently taken that position with respect to Anti-Kickback Statute violations. As a result of the U.S. Health Care Reform Legislation, the Anti-Kickback Statute has been amended to confirm that

a violation of the Anti-Kickback Statute may trigger *False Claims Act* liability as well. In addition, the U.S. Health Care Reform Legislation eliminated the knowledge standard applicable to Anti-Kickback Statute violations, which makes it easier for violations of the Anti-Kickback Statute to be prosecuted. State law counterparts to these federal statutes also apply and provide additional penalties.

The federal Civil Money Penalty ("**CMP**") law covers a variety of practices. The CMP provides a means of administrative enforcement of the Anti-Kickback Statute, and prohibits false claims, beneficiary inducements, claims for medically unnecessary services, violations of Medicare participating provider or assignment agreements and other practices. Violations are subject to civil fines, exclusion from federal healthcare programs and other sanctions.

The U.S. federal *False Claims Act* provides, in part, that the federal government may bring a lawsuit against any person who it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to have a claim approved. The federal *False Claims Act* further provides that a lawsuit may be initiated in the name of the United States by a whistleblower who is an original source of the allegations. Violations of the federal *False Claims Act* may result in treble damages, civil penalties of between $5,500 and $11,000 for each false claim, and attorneys' fees. The U.S. Health Care Reform Legislation amended the *False Claims Act* to provide that the failure to return a known overpayment with the specified period of time will result in a false claim. State law counterparts to the federal *False Claims Act* also exist in many states. Under the DRA, states are encouraged to adopt false claims acts similar to the federal *False Claims Act*.

The *Health Insurance Portability and Accountability Act of 1996* ("**HIPAA**") also created federal statutes to prevent healthcare fraud and false statements relating to healthcare matters. The healthcare fraud statute prohibits knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private payors. A violation of this statute is a felony and may result in fines, imprisonment, or exclusion from government healthcare programs. The false statements statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious, or fraudulent statement in connection with the delivery of, or payment for, healthcare benefits, items, or services. A violation of this statute is a felony and may result in fines, imprisonment, or exclusion.

Both federal and state government agencies are continuing to increase their resources to combat healthcare fraud and to coordinate their enforcement efforts among various agencies such as the U.S. Department of Justice, the U.S. Department of Health and Human Services Office of Inspector General, and state Medicaid fraud control units.

Privacy of Patient Information

As an entity that submits claims for reimbursement from health insurers on behalf of radiology practices, each of ARS and CML RI is subject to information privacy rules under HIPAA. The U.S. Department of Health and Human Services ("**HHS**") enforces privacy regulations under HIPAA that govern the use, disclosure, transmission, and retention of "protected health information". In addition, HHS has established security standards under HIPAA governing the electronic exchange of health information. Violations of these requirements could result in substantial civil or criminal liability for American Radiology Associates, P.A. ("**ARA**") and TII. Because ARS is a Business Associate to ARA, its contracted radiology practice, and CML RI is a Business Associate to TII, its contracted radiology practice, each of ARS and CML RI has certain contractual obligations to maintain privacy and security standards as well.

On February 17, 2009, the *Health Information Technology for Economic and Clinical Health Act* (the "**HITECH Act**"), as part of the *American Recovery and Reinvestment Act*, was signed. The HITECH Act includes a number of measures targeted to increase HIPAA compliance efforts, including establishing a new requirement to notify patients and the HHS of any unauthorized breaches of "protected health information", strengthening the requirements with respect to accounting of disclosures, and expanding the penalties for HIPAA violations to Business Associates.

In addition to federal regulations issued under HIPAA, some states have enacted privacy and security statutes or regulations that, in some cases, are more stringent than those issued under HIPAA.

Corporate Practice of Medicine, Licensure, and Credentialing

Medical licensure and credentialing in the United States is regulated by the individual states. Many states prohibit a lay person or any entity other than a professional corporation or other similar professional organization from practicing medicine, including by employing professional persons or by having any ownership interest or profit participation in or control over, any medical professional practice. The laws of such states also prohibit a lay person or a non-professional entity from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. ARS and CML RI have structured their relationships with their respective radiology groups under their management services agreements in a manner that management believes does not constitute the practice of medicine by ARS or CML RI.

The ownership, operation, expansion, and acquisition of diagnostic imaging equipment and facilities are subject to various federal and state laws, regulations and approvals concerning certificates of need and the licencing of equipment, facilities, and personnel. Certificate of need laws were enacted to contain rising healthcare costs, prevent the unnecessary duplication of health resources, and increase patient access to health services. In practice, certificate of need laws have prevented hospitals and other providers, who have been unable to obtain a certification of need from acquiring new machines or offering new services. Certificate of need laws are the subject of continuing legislative activity.

The radiology services provided by ARS' and CML RI's contracted radiologist practices are subject to state medical practice laws. The teleradiology service, American Radiology Solutions, involves contracts for the practice of medicine across state lines. The medical practitioners providing such services must comply with the applicable credentialing and medical practice laws of all relevant states.

Mammography Quality Standards

Any provider of screening and diagnostic mammography imaging services is also subject to regulation under the federal *Mammography Quality Standards Act* ("**MQSA**"). Under the MQSA, the Food and Drug Administration ("**FDA**") promulgates quality standards applicable to mammography, carries out an enforcement program involving on-site inspections of mammography facilities, and is authorized to impose sanctions for non-compliance. In addition, FDA-recognized accreditation bodies are responsible for evaluating and accrediting facilities to perform screening or diagnostic mammography services. Violation of these standards may result in various sanctions, including monetary penalties or suspension of certification,

Accreditation Standards for Imaging Services

Medicare Improvement for Patients and Providers Act of 2008 provides that suppliers of imaging services will be required to receive accreditation by a nationally recognized accrediting organization in order to receive reimbursement from Medicare as of January 1, 2012. CMS selected the American College of Radiology, the Joint Commission and the Intersocietal Accreditation Commission as the accrediting organizations authorized to accredit technical component suppliers of advanced imaging services. The accreditation standards could impose additional requirements on imaging providers.

Initiative to Reduce Unnecessary Radiation Exposure

On February 9, 2010, the FDA announced an initiative to reduce unnecessary radiation exposure from CT, nuclear medicine studies, and fluoroscopy. The FDA announced its intention to issue requirements for manufacturers of imaging equipment to incorporate important safeguards into the design of their machines to develop safer technologies and to provide appropriate training to support safe use of their machines by practitioners. On November 8, 2010, the FDA issued a letter to the Medical Imaging Technology Alliance regarding certain CT equipment features that may have contributed to the unintended high exposure of radiation and requested comments from industry on the recommendations. In addition, the FDA and CMS have announced that the agencies are collaborating on developing certain quality assurance practices that may be incorporated into the mandatory accreditation requirements for imaging suppliers and the Medicare survey process for imaging centres and hospitals providing imaging services. These standards, if finalized, could impose additional requirements on imaging providers.

Environmental Health and Safety Laws

Any provider is subject to federal, state and local regulations governing the storage, use, transport, and disposal of materials and waste products, including biohazardous and radioactive wastes. PET services and some other medical imaging services require the use of radioactive materials. Although these materials and wastes have short half-lives, quickly breaking down into inert substances, the use of such materials presents the risk of accidental environmental contamination and physical injury.

Insurance Laws and Regulations

Many states have adopted certain laws and regulations affecting risk assumption in the healthcare industry, including those that subject any physician or physician network engaged in risk-based managed care to applicable insurance laws and regulations. These laws and regulations may require physicians and physician networks to meet minimum capital requirements and other safety and soundness requirements.

Limitations on Reimbursement

The U.S. Health Care Reform Legislation has resulted in reductions in Medicare payments for technical component services and may impact reimbursement and utilization levels for imaging services as this law is implemented over the next several years. For further discussion relating to the limitations on reimbursement, see “Corporate Structure — Recent Developments — *Continued Downward Pressure on Reimbursement Rates in the United States*” above. Congress and CMS continue to evaluate various proposals that could result in further reductions in reimbursement and utilization for imaging services in the future.

Professional Radiology Services

Canada

CML contracts with individual radiologists or radiology groups to provide diagnostic interpretations of the images generated at CML’s owned and operated medical imaging centres. As compensation for their services, radiologists receive an agreed-upon percentage of the amounts paid by government insurance plans or other third party payors for services provided at the centres, typically varying between 20% to 25% of global net revenue or collections of the professional fees.

United States

In the states in which CML’s U.S. operating subsidiaries provide services, a lay person or any entity other than a professional corporation or similar professional organization is not allowed to practice medicine, including by employing professional persons or by having any ownership interest or profit participation in, or control over, any medical professional practice. This doctrine is commonly referred to as the prohibition on the “corporate practice” of medicine. In order to comply with this prohibition, CML’s U.S. operating subsidiaries contract with radiologists to provide professional medical services in its facilities, including the supervision and interpretation of diagnostic imaging procedures. The radiology practice maintains full control over the physicians it employs. Pursuant to each management contract, CML’s U.S. operating subsidiaries make available the imaging centre and all of the furniture and medical equipment at the centre for use by the radiology practice, and the practice is responsible for staffing the centre with qualified professional medical personnel. In addition, CML’s U.S. operating subsidiaries provide management services and administration of the non-medical functions relating to the professional medical practice at the centre, including among other functions, provision of clerical and administrative personnel, bookkeeping and accounting services, billing and collection, provision of medical and office supplies, secretarial, reception, and transcription services, maintenance of medical records, and advertising, marketing, and promotional activities. As compensation for the services furnished under these contracts, CML’s U.S. operating subsidiaries generally receive an agreed upon percentage of the medical practice billings for, or collections from, services provided at the centre, typically varying between 75% to 85% of global net revenue or collections after deduction of the professional fees.

In Maryland, effective April 1, 2010, ARS and ARA entered into an amended and restated management services agreement (the "**MSA**"), which has an initial term of 62 months and will automatically be renewed for an additional five years unless terminated by either party.

Under the MSA, ARS provides medical imaging equipment, front-line staff and access to ARS's centres and certain management and administrative services to ARA, including accounting, payroll processing and benefit administration, credentialing and continuing medical education tracking, billing and collection, information and consulting services, in exchange for a fee based on percentage of global revenue collections from the imaging services performed. ARA maintains full control over the radiologists it employs. The MSA requires that a portion of the receivable due from ARA be converted to a long-term note receivable. The long-term note receivable estimated at U.S.$3.5 million bearing interest at the greater of prime plus 1.25% or 5.75%, is secured by accounts receivable of ARA and is due upon the expiration of the MSA.

Facilities

Canada

Each of CML's imaging centres is currently leased. These leases are on terms that are customary in the industry. The majority of these leases contain exclusivity clauses that ensure CML will be the only imaging centre in any given building in which it has leased premises. No one lease is material to CML's business. The current terms of these leases are scheduled to expire as follows:

Calendar Year	No. of Leases
2011	19
2012	15
2013 or later	43
Month to Month	26
	103

United States

Each of CML's imaging centres, which include 17 locations in Maryland, one in Delaware and five in Rhode Island, is currently leased. These leases are on terms that are customary in the industry. The majority of these leases contain exclusivity clauses that ensure CML will be the only imaging centre in any given building in which it has leased premises. The current terms of these leases are scheduled to expire as follows:

Calendar Year	No. of Leases
2011	4
2012	4
2013 or later	15
	23

Employees

Canada

As at December 3l, 2010, CML employed 679 full-time and 456 part-time employees in its imaging services business, approximately 21% of which were unionized as further described in the table below. CML's management believes that its relationship with its unionized employees continues to be good.

Employee Group	Location	Employees	Union	Agreement Expiry Date
Imaging and clerical employees	Sudbury, Ontario	38	OPSEU Local 668	February 28, 2014
Imaging and clerical employees	Victoria, B.C.	197	Health Sciences Association of British Columbia	December 31, 2015

United States

As at December 31, 2010, CML employed 576 full-time and 255 part-time employees in its imaging services business, none of whom are unionized.

Competition

Canada

CML operates the largest network of community-based medical imaging centres in Canada. CML operates centres in Ontario, British Columbia, Alberta, Manitoba, and Quebec. The medical imaging services industry in Canada is highly fragmented, with many independent radiologists and small imaging centres. Hospitals also provide competition in some provinces. The size of CML's medical imaging services operation produces economies of scale in equipment purchases and maintenance, consumable purchases, staffing and centre management and radiologist interpretation services. The limited availability of licences being granted in British Columbia, Ontario, Manitoba and Quebec and the capital cost associated with establishing a medical imaging centre makes it difficult for potential competitors to enter the medical imaging market.

United States

Our U.S. operations compete locally with radiologist groups, hospitals, centres, and other independent organizations that operate imaging equipment. There are approximately 221 such sites in Maryland, of which ARS operates 17, and approximately 49 sites in Rhode Island, of which CML RI operates five. There are five operators in Maryland with five or more sites, one of which operates more sites than ARS, and there are three operators in Rhode Island that operate more sites than CML RI.

Management believes some of the largest fixed site medical imaging companies in the United States are RadNet Inc., Diagnostic Health Corporation, Insight Imaging, LLC, MedQuest Associates, Alliance Imaging, Inc. and Center for Diagnostic Imaging, of which the first two operate in Maryland and none operate in Rhode Island. The competitive landscape for outpatient services sector in the United States is highly fragmented, with only two publicly-traded entities (Alliance Imaging Inc. and RadNet Inc.). See "Risk Factors — Risks Relating to the Business Operations in the U.S. Imaging Market — Competition from Other Medical Imaging Companies and Hospitals".

Seasonality

CML's revenue and EBITDA from its medical imaging businesses are subject to some seasonality. Major holidays, such as Thanksgiving and Christmas in the fourth quarter and summer vacations in July and August, could affect doctors' office visits, and hence, referrals to diagnostic imaging services.

Potential Growth

The Canadian and U.S. medical imaging markets are both highly fragmented. CML is the largest provider of medical imaging services in Canada where management estimates it has approximately 13% of the market share. In the U.S., management believes CML has less than a one percent market share.

Since 2007, CML has completed acquisitions of 25 medical imaging centres in Canada and 24 centres in the U.S., representing an aggregate of approximately $134 million in new revenue in 2010. CML intends to continue to evaluate opportunities to expand its network, and may selectively pursue acquisitions or develop greenfield centres that are expected to be accretive to Distributable Cash where, among other considerations: the regulatory environment permits; there is sufficient patient demand for outpatient diagnostic services; there is an opportunity to gain significant market share; payors are receptive to CML's entry into the market; and CML has adequate financial resources to expand.

In addition, management believes that demand for MRI and other advanced imaging modalities will continue to increase as physician and patient awareness of their benefits increases, particularly in Canada. Emerging, advanced imaging modalities, such as PET, may also provide opportunities for growth, particularly in Canada where its use is currently more limited.

Central to CML's strategy for its medical imaging centres is to complete the digitization of its facilities across Canada, including the implementation of an integrated RIS/PACS system. This new system has been rolled out across the majority of CML's U.S. operations. Management believes that by fully networking its medical imaging centres, CML can achieve greater visibility in procedural availability for patients and enhance capacity utilization, thereby increasing revenue and market share. These initiatives will also prepare CML for the future of digital medical imaging, electronic health records, and teleradiology, and deliver enhanced care for patients and physicians.

CML is also focused on raising awareness of its diagnostic services through a national branding program aimed at Canadian healthcare providers and patients. A refurbishment initiative to enhance patient experience could also drive increased patient throughput.

Credit Facilities

In connection with the acquisition of ARS, CML as borrower, entered into a credit agreement dated as of February 22, 2008 with The Toronto-Dominion Bank and a syndicate of lenders, which was amended and restated as of January 1, 2011 (the "**Credit Agreement**").

The following is a summary of the material terms and conditions contained in the Credit Agreement, and is qualified in its entirety by reference to the provisions of the Credit Agreement.

Summary of Facilities

Term Facility: A term facility in the principal amount of $275 million with a term of five years, maturing on February 22, 2013. The term facility was made available to finance the purchase price of the acquisition of ARS, fees and expenses related to such acquisition, and the early repayment of the $190 million principal amount of 5.754% senior secured guaranteed notes of CML that were due August 6, 2011, including the "make whole" payment associated with the early repayment of such notes. The term facility bears interest at a floating rate based on the Canadian dollar prime rate, the banker's acceptance rate, the U.S. dollar base rate or U.S. dollar LIBOR, plus in each case, an applicable margin to those rates based on the duration for which the term facility has been outstanding. CML has entered into an interest rate swap agreement at a fixed rate of 4.078% on $200 million of the term facility (plus applicable margins that range from 55 to 100 basis points) for a period of five years.

Revolver: A revolving credit facility in the principal amount of $100 million with a term of five years. The revolver bears interest at a floating rate based on the Canadian dollar prime rate, the banker's acceptance rate, the U.S. dollar base rate or U.S. dollar LIBOR, plus in each case, an applicable margin to those rates based on the ratio of total debt to pro forma adjusted EBITDA (as defined in the Credit Agreement) from time to time.

The one year bridge loan of $75 million was fully repaid during the third quarter of fiscal 2008.

Covenants

The Credit Agreement contains customary affirmative, reporting, and negative covenants.

Pursuant to the terms of the Credit Agreement, CML is required to maintain, on a quarterly pro forma basis, (i) a prescribed consolidated total debt to pro forma consolidated EBITDA ratio not to exceed 3:1 and (ii) a prescribed consolidated EBITDA to consolidated interest ratio of not less than 4:1. In addition, the Credit Agreement imposes restrictions on the ability of CML to incur additional debt, make liens, dispose of assets, consolidate, merge or acquire other businesses, or make distributions that exceed Distributable Cash. These covenants restrict numerous aspects of CML's business.

Events of Default

The Credit Agreement contains customary events of default. Failure to comply with the terms of the Credit Agreement entitles the lenders to accelerate all amounts outstanding under the credit facilities.

The Credit Agreement, in certain circumstances, restricts the ability of CML to make payments in respect of its securities unless sufficient funds are available for the repayment of indebtedness and the payment of interest, expenses, and taxes.

RISK FACTORS

The following information is a summary only of certain risk factors and is qualified in its entirety by reference to, and must be read in conjunction with, the detailed information appearing elsewhere in this Annual Information Form. These risks and uncertainties are not the only ones facing CML. Additional risks and uncertainties not currently known to CML, or that CML currently considers immaterial, may also impair the operations of CML. If any such risks actually occur, the business, financial condition, or liquidity and results of operations of CML, and the ability of CML to pay dividends on its common shares, could be materially adversely affected. The terms "we" and "our" as used in this Section refer to CML and/or its various affiliates, as the context may require.

Risks Relating to the Business

In addition to risks specific to the U.S. market (see " – Risks Relating to the Business Operations in the U.S. Imaging Market"), the following are some of the risks and uncertainties relating to CML's business.

Dependence on Government Funding

A substantial portion of CML's revenue is derived from fees for diagnostic services paid to CML from government health insurance programs in Canada and the United States. CML's ability to maintain or increase its revenue is therefore highly dependent on the commitment of public health authorities to continue funding the diagnostic services performed by CML.

With growing financial pressures on the healthcare system in both Canada and the U.S., new funding structures are being implemented by all levels of government in both countries. These new funding structures are highly focused on cost containment, which is a trend that is expected to continue in the future. Any funding reductions or other changes in payment policies for healthcare services could have a material adverse effect on CML.

Approximately 49% of the consolidated revenue generated by CML in fiscal 2010 was derived from fees for diagnostic services paid by the health insurance program administered by the MOH. In Ontario, which currently has a budget deficit estimated at approximately $21.5 billion, there has been no increase in the technical fees paid for imaging services, or in the price for Ontario Health Insurance Plan-covered laboratory tests, since 2005. The current funding agreement between the MOH and the OAML expires on March 31, 2011. Negotiations between the OAML and MOH for a new funding agreement have not started as at March 31, 2011. There can be no assurance as to the terms of any future funding agreements or the potential financial impact on CML of any such new agreements.

Certain provisions of the U.S. Health Care Reform Legislation have the effect of reducing Medicare reimbursement for imaging services and could also potentially decrease utilization of these services. This legislation is currently the subject of a number of court cases challenging its constitutionality and the continued focus of debate among Congress, state governors, and legislators, creating uncertainty as to the ultimate financial impact of these reforms; however, unless they are repealed, such provisions, together with a number of other recently announced changes to Medicare reimbursement, are expected to negatively affect revenues from CML's U.S. operations.

Current Economic Situation

The healthcare services sector in Canada, from which CML derives approximately 76% of its revenue, has historically been less sensitive to economic cycles and volatility than certain other business sectors primarily due to universal healthcare.

In the U.S., the economic downturn has led to high unemployment and the loss of company-provided healthcare benefits. Moreover, the economic slowdown could negatively impact payors' ability or willingness to pay for medical procedures. These factors have negatively impacted, and could continue to negatively impact, operating results from CML's U.S. operations.

Government Regulation

Community-based laboratories and imaging centres are subject to significant regulation and licencing requirements from all levels of government. The licencing and regulatory requirements relate to, among other matters, the conduct of testing and reporting results, the handling and disposal of medical specimens and infectious and hazardous waste and other materials, the safety and health of employees, and the proficiency of staff. Medical testing laboratories and imaging centres are also subject to periodic inspections by regulatory agencies. A failure by CML to comply with laws and regulations could expose it to significant penalties and may result in civil or criminal sanctions, including: the revocation of licences, certifications, and authorizations; the denial of the right to conduct business; and the exclusion from participation in government healthcare programs. The imposition of any of these sanctions could have a material adverse effect on CML. Licences are rarely issued and if a laboratory or centre operated by CML had its licence revoked, there is no assurance that it will be issued a new licence.

In addition to existing government healthcare regulations, there are ongoing initiatives at the federal and provincial levels for comprehensive reforms to existing legislation and policy governing the provision of healthcare services, including the payment for, and availability of, particular services. CML believes that such initiatives will continue for the foreseeable future and could increase the cost of compliance for CML. Certain aspects of these reforms, if adopted, could materially and adversely affect CML's business, financial condition, and results of operations.

Funding Model

Currently, CML's laboratory testing business is reimbursed under a capped agreement with the MOH while its medical imaging business receives fees under a fee-for-service model. In a weak economic environment and where the provincial government is operating under a budget deficit, there is no guarantee that these funding models could not change to the detriment of CML's business.

Competition

CML's major competitors in the community-based laboratory sector in Ontario are LifeLabs and Gamma-Dynacare Medical Laboratories (See "Information Concerning CML — Competition"). The current funding model applicable to laboratory services in Ontario, together with the inability to obtain required licences except through acquisition, somewhat reduces competitive pressures. Beyond Ontario, competitors may compete for referrals from doctors and the services of trained technicians, as well as for acquisitions of existing laboratories. There can be no assurance that CML will be able to compete effectively for the acquisition of existing laboratories, or that such competition will not make it more difficult or expensive to acquire existing laboratories/licences on terms beneficial or attractive to CML.

Although the imaging sector is currently fragmented in Canada, there is little to prevent competition from entering the market. Competition could come from community-based facilities in a particular geographical community; from a conglomerate of facilities operating on a national or North American basis; or from hospitals which may directly acquire and operate imaging equipment on-site as part of their overall out-patient servicing capability. CML also competes for the provision of services from independent professional radiologists and trained technicians. Hospitals also provide competition in all provinces. Competitors with greater capital and/or experience may enter the market or compete for referrals from doctors and the services of available radiologists and trained technicians, as well as for acquisitions of existing imaging facilities. There can be no assurance that CML will be able to compete effectively for the acquisition of existing facilities; that additional competitors will not enter the market; that such competition will not make it more difficult or expensive to acquire existing facilities on terms beneficial or attractive to CML; or that competitive pressures in the provision of particular modalities in a geographic region will not otherwise adversely affect CML.

Growth Strategy and Integration

CML may pursue growth through acquisitions. There is no assurance that it will be able to acquire medical laboratories or imaging centres on satisfactory terms, or at all. The successful integration and management of acquired businesses involves numerous risks that could adversely affect CML's growth and profitability, including: the risk that CML's management may not be able to successfully manage the acquired operations and that the integration may place significant demands on its management, diverting their attention from existing operations; the risk that CML's operational, financial, and management systems may be incompatible with, or inadequate to effectively integrate and manage, acquired systems; the risk that acquisitions may require substantial financial resources that otherwise could be used in the development of other aspects of CML's business; the risk that acquisitions may result in liabilities and contingencies which could be significant to CML's operations; and the risk that personnel from CML's acquisitions and its existing businesses may not be able to work together successfully, which could affect the operation of its business. There is no assurance that CML will be able to successfully integrate its acquisitions and its failure to do so could adversely affect its business, operating results, and financial condition.

Liability and Insurance

Due to the nature of the services provided by CML, general liability claims may be asserted against CML with respect to the diagnostic services provided to patients, including, but not limited to, claims arising from reporting inaccurate results. Providing medical services subjects physicians to the risk of professional malpractice and other similar claims in Canada. Our relationships with contracted radiologists need to be structured in a manner that does not constitute the practice of medicine by us or subject us to professional malpractice claims for acts or omissions of these physicians. We believe that our service contracts with radiologists are structured in a manner that meets these objectives, but there remains a risk that such claims may be made against us. Although CML carries insurance for its laboratory and imaging operations, there can be no assurance that CML will have coverage of sufficient scope to satisfy any liability claim. CML believes that it will be able to obtain adequate insurance coverage in the future at acceptable costs, but there can be no assurance that it will be able to do so or that it will not incur significant liabilities in excess of policy limits. Any such claims that exceed the scope of coverage or applicable policy limits or an inability to obtain adequate coverage could have a material adverse effect on CML's business, financial condition, and results of operations.

Equipment Failure

Timely, effective service is essential to maintaining CML's reputation and revenue stream. The majority of CML's laboratory services are performed at its central laboratory located at 6560 Kennedy Road, Mississauga, Ontario. Any sustained interruption of the services performed at the central laboratory, which significantly affects the volume of testing or the accuracy and timeliness in the reporting of test results, could adversely affect CML's business, financial condition, and results of operations.

With respect to imaging services, high utilization rates are essential to maintaining and increasing revenues and operating efficiencies. The principal components of CML's operating costs include depreciation, salaries paid to technologists, fees paid to radiologists, annual system maintenance costs, insurance costs, and rental costs. Since the majority of these expenses are fixed, a reduction in the number of scans performed due to out-of-service equipment

will result in lower revenues and margins. If CML experiences more equipment malfunctions than anticipated, or if CML is unable to promptly obtain the services necessary to keep its equipment functioning effectively, its revenues could decline and its ability to maintain its reputation would be harmed, which could adversely affect its business, financial condition, and results of operations.

Patient Referrals

The success of a community-based laboratory or imaging centre in Canada is dependent upon physician referrals of patients. Referrals are made by physicians who have no contractual obligation or economic incentive to refer patients to laboratories or centres operated by CML. CML's centres compete for referrals with its major competitors in the private sector and with local service providers in the communities in which CML operates. CML is not dependent on any single referral source for a material portion of its revenue; however, if a sufficiently large number of physicians elected at any time to discontinue referring patients to CML, its business, financial condition, and results of operations would be materially adversely affected.

Information Technology Systems

CML's diagnostic services business depends, in part, on the continued and uninterrupted performance of CML's information technology systems. Sustained system failures or interruptions could disrupt CML's ability to process laboratory requisitions, perform testing, provide test results in a timely manner, and/or bill the appropriate party. CML's business, results of operations, and financial condition could be adversely affected by a system failure.

CML's computer systems are vulnerable to damage from a variety of sources, including systems and network failures, malicious human acts, and natural disasters. Moreover, despite network security measures, some of CML's servers are potentially vulnerable to physical or electronic break-ins, computer viruses and similar disruptive problems. Despite precautions taken by CML, unanticipated problems affecting CML's systems could cause interruption in its information technology systems. CML's insurance policies may not adequately compensate it for any losses that may occur due to any failures in its information technology systems.

Technological Change and Obsolescence

The technology used in the diagnostic services business is constantly undergoing development and change. New technologies may be developed, or existing technologies refined, which could render CML's existing equipment technologically or economically obsolete. The development of new technologies or new applications for existing technologies may require CML to adapt its existing systems or acquire new systems in order to successfully compete. Due to cost factors, competitive considerations or other constraints, there can be no assurance that CML will be able to acquire or have access to any new or improved equipment that CML may need in order to serve its stakeholders. Any inability of CML to provide state-of-the-art technologies may adversely affect CML's business, financial condition, and results of operation.

Key Personnel

CML's success depends on the skills, experience and effort of its senior management. The unplanned loss of services of one or more members of CML's key senior management personnel could significantly weaken CML's management expertise and its ability to deliver its services efficiently and profitably. In addition, the success of CML's laboratories and imaging centres depends on employing or contracting, as the case may be, qualified professionals such as technologists and radiologists. Currently, there is a shortage of qualified technologists and radiologists in certain parts of Canada that have been trained in an analog environment. While management believes that CML will be sufficiently staffed to effectively provide services to patients, the loss of healthcare professionals or the inability to recruit these individuals in CML's markets could adversely affect CML's ability to operate its business efficiently and profitably.

Privacy Laws

As a company that provides community-based laboratory testing and medical imaging services, CML is subject to certain privacy laws in Canada regulating the use, disclosure, transmission and retention of confidential personal

information, violations of which could result in substantial liability and expenses to comply with such laws. CML has implemented a program of information protection practices to ensure compliance with such regulations. Notwithstanding the foregoing, however, diligence and/or insurance coverage may not protect CML from all regulatory action and liability, particularly liability that may arise from its own negligent actions or misconduct. In such circumstances, CML could be materially and adversely affected if it is required to respond to regulatory action, pay damages, or bear the costs of defending any claim which is beyond the level of CML's insurance coverage. Further, there can be no assurance that CML will be able to maintain such insurance coverage on terms acceptable to it.

Risks Relating to the Business Operations in the U.S. Imaging Market

If Contracted Radiology Practices Terminate Their Arrangements with Us, Our Access to Qualified Medical Professionals Could Substantially Diminish and Financial Results Would Be Adversely Affected

In many states, a lay person or any entity other than a professional corporation or similar professional organization is not permitted to practice medicine, including by employing professional persons or having an ownership interest or profit participation in, or control over, any medical professional practice. This is commonly referred to in the United States as the corporate practice of medicine doctrine.

In order to comply with this prohibition in the United States, we contract with radiology practices to manage their practice and office locations. The contractual relationships with radiology practices are an integral part of the management services model. The radiology practices provide many of the professional medical services at the locations owned or managed by imaging businesses. Should a radiology group's ability to perform services be curtailed or eliminated due to the loss of physicians, financial difficulties, or other circumstances, our business could substantially diminish. If a radiology group cannot perform its obligations, we may need to contract with one or more other radiology groups to provide the professional medical services at the affected locations. We may not be able to locate radiology groups willing to provide those services on terms acceptable to us, if at all. Even if we were able to do so, any replacement radiology group's relationships with referring physicians may not be as extensive as those of the existing, contracted radiology practices. In addition, the radiology groups are parties to the managed care contracts from which we derive revenue. If we were not able to readily replace these contracts, our revenue would be negatively affected. In any such event, our business in the United States could be seriously harmed.

In the case of ARS and CML RI, under the respective management services agreements, ARA and TII currently provide, directly or indirectly with other radiologists, all of the professional medical services at the locations managed by ARS and CML RI, and for hospitals in the case of ARS. Although the respective management services agreements are long-term arrangements, ARA and TII have limited customary termination rights. Also, the radiology groups' ability to continue performing their obligations may be curtailed or eliminated due to loss of physicians or other circumstances. If ARA or TII cannot perform their obligations, CML's business in the United States could be seriously harmed for the reasons stated in the foregoing paragraph.

In addition, at times there has been a shortage of qualified radiologists in the regional markets we serve. Competition in recruiting radiologists also may make it difficult for contracted radiology practices to maintain adequate levels of radiologists. If a significant number of radiologists terminate their relationships with our contracted radiology practices, and those practices cannot recruit sufficient qualified radiologists, our ability to maximize the use of our medical imaging locations and our financial results could be adversely affected.

Patient Referrals

A significant reduction in physician referrals would have a negative impact on our business in the United States. We derive a substantial amount of our revenue, directly or indirectly, from fees charged for the medical imaging services we manage. Our U.S. business depends on referrals of patients from unaffiliated physicians and other third parties who have no contractual obligations to refer patients to the radiology practices with whom we contract. If a sufficiently large number of these physicians and other third parties were to discontinue referring patients to the office locations that we manage, the volume of diagnostic imaging procedures could decrease, which would reduce revenues and operating margins. Further, commercial third-party payors have implemented programs that could limit the ability of physicians to refer patients to our contracted radiology practices. For example, prepaid healthcare plans, such as health maintenance organizations, sometimes contract directly with providers and require their

enrollees to obtain these services exclusively from those providers. Some insurance companies and self-insured employers also limit these services to contracted providers. These “closed panel” systems are now common in the managed care environment. Other systems create an economic disincentive for referrals to providers outside the system’s designated panel of providers. If our contracted radiology practices are unable to compete successfully for these managed care contracts, our results and prospects for growth in the United States could be adversely affected.

Changes in Third-Party Reimbursement Rates or Methodology for Medical Imaging Services Could Result in a Decline in Revenue and Negatively Impact Our Business in the United States

The fees charged in the United States for medical imaging services are primarily paid by insurance companies, Medicare and Medicaid, workers compensation, private and other payors. Any change in the rates of, or conditions for, reimbursement from these sources could substantially reduce the amounts reimbursed for diagnostic imaging services and the amounts paid to us for our management services. The U.S. Health Care Reform Legislation and CMS have adopted measures to decrease costs under Medicare. Similar measures have been adopted by Medicaid and certain private payors to reduce reimbursement. Medicaid and private payors continue to introduce cost reductions and measures to control utilization of imaging services. Both CMS and private payors continue to evaluate various proposals that could result in further reductions in reimbursement for diagnostic imaging procedures in the United States

Pressure to Control Healthcare Costs in the United States Could Have a Negative Impact on Results

The medical imaging industry in the U.S. is currently under pressure to better manage utilization of imaging procedures to avoid excessive costs to healthcare payors and enhanced risks to patients, which could result in lower patient volumes. There is also a strong downward pressure on reimbursement rates creating uncertainty around levels of reimbursements in the future for imaging procedures. Payment rates with private payors may be reduced if Medicare reimbursement levels decline. Private payors continue to increase deductibles, premiums, and co-insurance amounts as a measure to control the cost of healthcare. Other payors have implemented the use of radiology benefit managers and prior authorization programs as a measure to control utilization and the cost of diagnostic imaging procedures. These strategies could have a negative effect on revenues for CML.

Competition from Other Medical Imaging Companies and Hospitals

The market for medical imaging services in the United States is highly competitive. We compete principally on the basis of our reputation, our ability to provide multiple modalities at many of our centres, the location of our centres, and the quality of our medical imaging services. We compete locally with groups of radiologists, established hospitals, and other independent organizations that operate imaging equipment. Major national competitors include RadNet Inc., Diagnostic Health Corporation, Insight Imaging, LLC, MedQuest Associates, Alliance Imaging, Inc., and Center for Diagnostic Imaging. Some of our competitors may now, or in the future, have access to greater financial resources than we do and may have access to newer, more advanced equipment. In addition, some physician practices have established their own medical imaging locations within their group practices which may compete with our office locations.

Technological Change in the Industry Could Reduce the Demand for Services and Require Us to Incur Significant Costs to Upgrade Our Equipment in the United States

The development of new technologies or refinements of existing modalities may require us to upgrade and enhance our existing equipment in the United States before we may otherwise intend. Many companies currently manufacture medical imaging equipment. Competition among manufacturers for a greater share of the medical imaging equipment market may result in technological advances in the speed and imaging capacity of new equipment. This may accelerate the obsolescence of our equipment, and we may not have the financial ability to acquire new or improved equipment. In that event, we may be unable to deliver services in the efficient and effective manner that payors, physicians and patients expect, which could negatively affect our revenue in the United States.

Exposure to Professional Malpractice Liability

Providing medical services subjects physicians to the risk of professional malpractice and other similar claims in the United States. Our relationships with contracted radiology practices will need to be structured in a manner that does

not constitute the practice of medicine by us, or subject us to professional malpractice claims for acts or omissions of physicians employed by the contracted radiology practices. We believe that the relationships with ARA and TII are structured in a manner that meets these objectives. We may be subject to professional liability claims, including, without limitation, for improper use or malfunction of medical imaging equipment, and for acts and omissions of our technologists. We may not be able to maintain adequate liability insurance to protect against those claims at acceptable costs, or at all.

Any claim made against us that is not fully covered by insurance could be costly to defend, result in a substantial damage award against us, and divert the attention of management from operations, all of which could have an adverse effect on financial performance. In addition, successful claims against us may adversely affect our business or reputation in the United States.

Relationship with The Johns Hopkins University and The Johns Hopkins Health Services Corporation is Subject to Termination

ARS has a number of relationships with The Johns Hopkins University and The Johns Hopkins Health Services Corporation and affiliated hospitals and physicians. Johns Hopkins is a referral source for ARA and a landlord for two high volume centres that comprise a significant portion of ARS's revenue. Johns Hopkins also provides reading coverage to ARA. Johns Hopkins has its own business strategy and could decide to terminate its relationship with us or pursue new opportunities in diagnostic medical imaging that may compete with our business, including operating the two high volumes centres previously noted, at the expiry or termination of the respective leases, in which Johns Hopkins is a landlord. Termination of any one of these relationships could disrupt our business, and could negatively affect our revenue and earnings in the United States.

Currency Fluctuations

CML reports its financial results in Canadian dollars. Our business in the United States is carried out in U.S. dollars. CML may therefore be affected by movements of the U.S. dollar against the Canadian dollar. Significant long-term fluctuations in the relative value of the U.S. dollar and the Canadian dollar could have an adverse effect on CML's business, financial condition, and results of operations.

Expansion in the United States

As part of our business strategy, we may increase our presence in the areas we serve in the United States through one or a combination of selectively acquiring locations, developing new locations, adding equipment at existing locations, and directly or indirectly entering into contractual relationships with high-quality radiology practices.

However, our ability to successfully expand in the United States depends upon many factors, including the ability to:

- identify attractive and willing candidates for acquisitions on acceptable purchase terms;
- identify locations in existing or new markets for development of new centres;
- comply with legal requirements affecting our arrangements with contracted radiology practices, including state prohibitions on fee-splitting, corporate practice of medicine, and self-referrals;
- obtain regulatory approvals where necessary and comply with licensing and certification requirements applicable to its medical imaging offices, diagnostic imaging equipment, the contracted radiology practices, and the physicians associated with the contracted radiology practices;
- recruit a sufficient number of qualified radiology technologists and other non-medical personnel;
- expand its infrastructure and management; and

- compete for opportunities. We may not be able to compete effectively for the acquisition of medical imaging operations. Our competitors may have more established operating histories and greater resources. Competition may also make any acquisitions more expensive.

U.S. Income Tax Matters

For U.S. Federal income tax purposes, a forward agreement between Raven Holdings and CML (the "**Forward Agreement**"), which requires Raven Holdings to repurchase preferred stock ("**ARS Holding Preferred Stock**") of ARS Holding, Inc., the holding company of ARS ("**ARS Holding**"), from CML, has been structured to be treated as a financing transaction with Raven Holdings as the borrower and CML as the lender. So viewed, distributions made on the ARS Holding Preferred Stock to CML should be treated as interest expense of Raven Holding rather than dividend distributions. No assurance can be given that the Internal Revenue Service will respect this structure and will not seek to recharacterize this treatment.

There is a risk that the Internal Revenue Service could assert that the financing transaction with respect to the ARS Holding Preferred Stock should not be treated as indebtedness of Raven Holdings, but rather should be treated in accordance with its form as non-deductible distributions on the ARS Holding Preferred Stock. In that case, Raven Holdings would not be entitled to a deduction for the deemed interest paid in the form of distributions on the ARS Holding Preferred Stock, which could materially increase its taxable income and therefore its U.S. Federal income tax liability. Other limitations of U.S. Federal income tax law may apply to reduce or eliminate the deduction for interest deemed paid by Raven Holdings. For example, the interest rate may be found to be in excess of an arm's length rate. In addition, Section 163(j) of the Internal Revenue Code of 1986, as amended, (the "**Code**") may apply to reduce or eliminate a deduction for interest by Raven Holdings if its ratio of debt to equity exceeds 1.5 to 1 and if certain other conditions apply. Accordingly, no assurance can be given that Raven Holdings will be able to deduct the deemed interest payments made with respect to the ARS Holding Preferred Stock pursuant to the Forward Agreement, whether or not the Forward Agreement is respected as a financing transaction. However, management believes that the impact of any increased U.S. federal income tax should not be material to CML or to the level of dividends paid by CML.

If the distributions made to CML on the ARS Holding Preferred Stock are not treated as deemed interest payments, such distributions may be subject to a 5% U.S. withholding tax pursuant to the Canada - United States Income Tax Convention (the "**Convention**") to the extent of the current or accumulated earnings and profits of Raven Holdings.

Distributions made to CML in calendar year 2009 on the ARS Holding Preferred Stock were subject to a 4% U.S. withholding tax pursuant to the Convention. This rate of withholding tax was reduced to 0% for distributions made to CML after 2009.

No assurance can be given that U.S. federal income tax laws will not adversely be amended with retroactive effect, or that administrative and regulatory guidance will not be issued by the Internal Revenue Service or the Department of the Treasury, which could adversely affect the financing transaction or the taxation of Raven Holdings, ARS Holdings, or CML.

Risks Relating to Regulation of Our Business in the United States

Different Regulatory Environment

Senior management has limited experience in the U.S. medical imaging market which has a different regulatory environment and different market practices and competitors than the Canadian medical imaging market.

Complying with U.S. federal and state regulations is an expensive and time-consuming process, and any failure to comply could result in substantial penalties.

We Are Subject, Directly or Indirectly Through the Radiology Practices with which We Contract, to Extensive Regulation by Both the Federal Government of the United States and the State Governments of the States in which We Provide Services

If our operations are found to be in violation of any of the U.S. federal or state laws and regulations to which we or the radiology practices with which we contract are subject, we may be subject to the applicable penalty associated with the violation, including civil and criminal penalties, damages, fines, exclusion from public healthcare programs, and the curtailment of operations. Any penalties, damages, exclusion, fines, or curtailment of our operations, individually or in the aggregate, could adversely affect our ability to operate our business and, in turn, the financial results of our U.S. operations. The risk of our being found in violation of these laws and regulations is increased by the fact that many of these laws and regulations have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of interpretations. See "Information Concerning CML — Regulation". Any action brought against us for violation of these laws or regulations, even if successfully defended by us, could cause us to incur significant legal expenses and divert management's attention from business operations.

Non-Compliance with U.S. Federal and State Billing and Reimbursement Laws and Regulations Can Result in Substantial Penalties, Including Program Exclusion

Various U.S. federal and state laws and regulations establish complex rules for the billing of health services for reimbursement and prescribe penalties for non-compliance with such rules. The U.S. federal *False Claims Act* provides, in part, that the federal government may bring a lawsuit against any person who it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. It also permits private whistleblowers to initiate so-called "qui tam" actions in the name of the government alleging improper billing practices. Many states have adopted similar state false claims act in response to the DRA, which provides a financial incentive for states to enact false claims acts.

In addition, legislation may be enacted in the future that imposes additional requirements or burdens on our U.S. operations. Federal and state enforcement authorities have increased their enforcement activities with respect to the federal and state false claim acts. Healthcare fraud laws at both the federal and state levels are broadly construed and can lead to significant civil or criminal penalties, including exclusion from participation in public healthcare programs. Our large volume of billing and collection activities in the United States requires our continued attention to the accuracy and compliance of the claims we submit, and exposes us to potential liability under these statutes if billing is not done correctly.

U.S. Federal and State Fraud and Abuse Laws May Adversely Affect Income

Various U.S. federal and state laws govern financial arrangements among healthcare providers. The U.S. federal Anti-Kickback Statute prohibits the knowing and wilful offer, payment, solicitation, or receipt of any form of remuneration in return for, or to induce, the referral of Medicare, Medicaid, or other U.S. federal healthcare program beneficiaries, or in return for, or to induce, the purchase, lease, or order of items or services that are covered by Medicare, Medicaid, or other federal healthcare programs. Similarly, many state laws prohibit the solicitation, payment, or receipt of remuneration in return for, or to induce, the referral of patients in private as well as government programs. Violation of these anti-kickback laws may result in substantial civil or criminal penalties for individuals or entities, or exclusion from federal or state healthcare programs. We believe we are operating in compliance with applicable laws and that our arrangements with providers would not be found to violate the anti-kickback laws. However, these laws could be interpreted in a manner inconsistent with our understanding and operations.

The federal Stark Law prohibits a physician from referring Medicare or Medicaid patients to an entity for certain "designated health services", including certain radiology services, if the physician has a prohibited financial relationship with that entity, unless an exception applies. Although we believe our operations do not violate the Stark Law, our activities may be challenged. If a challenge to our activities is successful, this could have an adverse effect on our operations in the United States.

Federal regulatory and law enforcement authorities have recently increased enforcement activities with respect to the Anti-Kickback Statute and the Stark Law. Our activities and those of any radiology practice with whom we contract may be investigated, claims may be against us or any radiology practice with whom we contract, and these increased enforcement activities may directly or indirectly have an adverse effect on our business, financial condition, and results of operations. In addition, legislation may be enacted and regulations may be adopted in the future that further addresses Medicare and Medicaid fraud and abuse or that imposes additional requirements or burdens on our U.S. operations.

All of the states in which our medical imaging centres are located have adopted a form of anti-kickback law and almost all of those states have also adopted a form of a self-referral law. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. Any action alleging a violation of these laws, even if successfully defended, could result in significant legal expenses and the diversion of financial and management resources. A determination of liability under these laws could result in fines and penalties and restrictions on our ability to operate in these jurisdictions, which could have a material adverse effect on CML.

If We Fail to Comply with Various Licencing, Certification and Accreditation Standards, We May Be Subject to Loss of Licencing, Certification, or Accreditation, Which Could Adversely Affect Our Operations in the United States

Ownership, construction, operation, expansion, and acquisition of medical imaging facilities are subject to various U.S. federal and state laws, regulations, and approvals concerning licencing of personnel, operation of certain types of healthcare facilities, adherence to quality standards, and operation of certain medical equipment. Other federal accreditation standards include those applicable to mammography services and additional accreditation standards will be imposed on diagnostic imaging services as required by the *Medicare Improvement for Patients and Providers Act of 2008*. In general, the failure to adhere to any of these federal or state requirements could preclude us from obtaining a new or renewal licence, certification, or accreditation, which would curtail our operations in the United States. Additionally, we may not be able to receive the required regulatory approvals for any future acquisitions, expansions, or replacements, and the failure to obtain these approvals could limit the opportunity to expand our services. In addition, certain medical imaging equipment we lease to our contracted radiology practices, such as mammography equipment and nuclear materials used in certain medical imaging studies, are subject to specific operational requirements. Non-compliance with these rules can expose us to other forms of liability if workers, patients, or others are exposed to safety risks.

Our medical imaging offices are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensure, certification, and accreditation. If any location loses its certification under the Medicare program, then the location will be ineligible to receive reimbursement from the Medicare and Medicaid programs. Our contracted radiology practices are subject to various requirements under their private payor contracts. If a practice or radiologist fails to comply with these requirements, it may be excluded from the network or may be subject to penalties and sanctions. A change in one centre's certification status could adversely affect other locations and, in turn, our U.S. operations as a whole. There has also been a slowdown in credentialing of physicians in the United States over the last several years that has lengthened billing and collection cycles in the industry. Such delays could negatively impact our ability to collect revenue from patients covered by Medicare.

Some managed care providers prefer to contract with accredited organizations. Any lapse in our accreditations could adversely affect our operations and financial results.

The Certificate of Need Regulations in Rhode Island Could Limit Our Ability to Grow and Expand in That Marketplace

Some states, including Rhode Island, where CML RI operates, require a Certificate of Need ("**CON**") or comparable regulatory approval prior to the acquisition of high-cost capital items, including medical imaging systems or the provision of medical imaging services by us and our contracted radiology practices. In many cases, a limited number of these certificates are available in a given state. If we are unable to obtain the applicable certificate or approval necessary to expand our operations, these regulations may limit or preclude our operations in the relevant jurisdictions.

Currently, in the state of Rhode Island, a CON is required for, but not limited to, the following activities:

- purchases of healthcare equipment in excess of U.S.$1,000,000;
- construction or renovation of a healthcare facility in excess of U.S.$2,000,000; or
- the offering of a new or expanded tertiary or specialty care service (which includes full-body CT and MRI).

CML RI does not currently have a CON as it was not required to obtain a CON at the time of the acquisition of substantially all of the assets of TII. However, in the future, the CON regulations could adversely affect our ability to grow and expand in that marketplace.

Violating HIPAA Patient Privacy Regulations Could Expose Us to Liability

As entities that submit claims for reimbursement from health insurers, our contracted radiology practices are subject to privacy rules under HIPAA. HHS HIPAA privacy regulations govern the use, disclosure, transmission, and retention of "protected health information". In addition, HHS has established security standards under HIPAA governing the electronic exchange of health information. Violations of these requirements could result in substantial civil or criminal liability for ARA, TII, ARS, and CML RI. Because we are a Business Associate to our contracted radiology practices, we have certain contractual obligations to maintain privacy and security standards.

Future U.S. Federal Legislation and Regulation Could Limit the Prices That Physicians and Suppliers Can Charge for Their Services, Which Could Reduce Our Revenue and Adversely Affect Our Operating Results

In addition to extensive existing government healthcare regulation, there are numerous initiatives affecting the coverage of, and payment for, healthcare services, including proposals that would significantly limit reimbursement under the Medicare program. Limitations on reimbursement amounts and other cost containment pressures have, in the past, resulted in a decrease in the revenue our contracted radiology practices receive for each medical imaging service it performs. Most notably, effective January 1, 2007, the DRA capped the payment for the "technical component" of medical imaging services reimbursed under the Medicare Physician Fee Schedule (for services rendered in physicians' offices) at the same level as payment provided under the Medicare out-patient hospital system. The result was a substantial reduction in Medicare payments for medical imaging services.

The enactment of the U.S. Health Care Reform Legislation will result in reductions in Medicare payments for technical component services and may impact reimbursement and utilization levels for imaging services as this law is implemented over the next several years, and could have a material impact on our business in the United States. See "Corporate Structure — Recent Developments — *Continued Downward Pressure on Reimbursement Rates in the United States*" above.

The overall reduction in reimbursement for technical component services may be less substantial than the Medicare regulations discussed above under "Regulation — Limitations on Reimbursements"; however, the reductions may be implemented at a more rapid pace. These same initiatives could affect competition in the industry, and could cause low margin providers and suppliers to exit the market. While it is difficult to make any predictions with respect to the U.S. Patient Protection Act or the likelihood of passage of the U.S. House Reconciliation Act, or the potential ultimate impact of these proposals, they are expected to result in reductions in Medicare payments, affect utilization levels, and could have a material impact on our business in the United States.

The U.S. Congress and CMS continue to evaluate various proposals whose effect, if adopted, on our business is uncertain. Aspects of certain proposals, if adopted, could result in reduced demand for our services and further reduce reimbursement and utilization for medical imaging services paid for under federal healthcare programs.

Our Agreements with Contracted Radiology Practices Must Be Structured to Avoid the Corporate Practice of Medicine and Fee-Splitting

U.S. state laws prohibit any non-licensed personnel or entity (including us) from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. These laws are enforced by state courts and regulatory authorities, each with broad discretion. There can be no assurance that present arrangements with our contracted radiology practices or with physicians providing medical services and medical supervision will not be challenged and, if challenged, that they will not be found to violate the corporate practice prohibition, subjecting us and our contracted radiology practices to potential damages, injunction and/or civil and criminal penalties, or require us to restructure our arrangements in a way that would affect the control over, or quality of, imaging services provided or our revenues. Any of these results could jeopardize our business.

We Could Be Subject to Liability for Injuries and Violations of Environmental and Health and Safety Laws

Some of the medical imaging procedures performed involve the use of materials, and generate biohazardous or medical or regulated waste, that may be subject to federal, state, and local environment and health and safety laws that regulate the storage, handling, and disposal of such material and waste. For example, patients are injected with a radioactive substance before undergoing a PET scan. Storage, use, and disposal of materials and waste products used and produced by us may present the risk of accidental environmental contamination or physical injury. We could incur significant costs and the diversion of management's attention in order to comply with current or future environmental and health and safety laws and regulations. Also, we cannot completely eliminate the risk of accidental contamination or injury from these materials and waste products. In the event of an accident, we could be held liable for any resulting damages, and any liability could exceed the limits, or fall outside, of our insurance coverage. We maintain professional liability insurance with coverage we feel is appropriate in light of the risks attendant to our business and consistent with industry standards. However, we may not be able to maintain insurance on acceptable terms, or at all.

The U.S. Regulatory Framework in which We Operate Is Uncertain and Evolving

U.S. federal and state healthcare laws and regulations may change significantly in the future. We monitor these developments and modify our operations from time to time as the regulatory environment changes. We cannot guarantee, however, that we will be able to adapt our operations to address new regulations or that new regulations will not adversely affect our business. In addition, although we believe that we are operating in compliance with applicable U.S. federal and state laws, neither our current nor anticipated business operations have been the subject of judicial or regulatory interpretation. We cannot guarantee that a review of our business by courts or regulatory authorities will not result in a determination that could adversely affect our operations, or that the U.S. healthcare regulatory environment will not change in a manner that restricts our operations.

Certain U.S. states have enacted statutes or adopted regulations affecting the assumption of financial risk in the healthcare industry, including statutes and regulations that subject physicians, or physician networks engaged in risk-based managed care, to insurance laws and regulations. These laws and regulations, if adopted in the states in which we operate, may require physicians and physician networks to meet minimum capital requirements or other safety and soundness requirements to assure their capacity to bear financial risk, which could result in substantial costs to our U.S. operations. The implementation of additional regulations or compliance requirements could result in substantial costs to us and the radiology practices with which we contract and limit the ability to enter into capitation and other risk-sharing managed care arrangements.

Risks Relating to the Common Shares

Payment of Dividends

Any decision to declare and pay dividends on the common shares will be made by the Board of Directors, in its sole and absolute discretion, and will depend on numerous factors, including, without limitation, CML's results of operations, cash requirements, financial condition, contractual restrictions, business opportunities, provisions of applicable law and other factors beyond the control of CML, or that the Board of Directors deems relevant at the time.

Structural Subordination of the Common Shares

In the event of a bankruptcy, liquidation, or reorganization of CML or any of its subsidiaries, holders of certain of their indebtedness and certain trade creditors will generally be entitled to payment of their claims from the assets of CML and those subsidiaries before any assets are made available for distribution to CML or its shareholders. The common shares will be effectively subordinated to most of the indebtedness and other liabilities of CML and its subsidiaries. Subject to the terms of the Credit Agreement, CML and its subsidiaries will be limited in their ability to incur secured and, in some respects, unsecured indebtedness.

Leverage and Restrictive Covenants

CML has third-party debt service obligations with respect to borrowings under the Credit Agreement. In addition, subject to the terms of the Credit Agreement, CML may borrow additional funds from other third parties. The degree to which CML is leveraged could significantly impact the amount of cash available to pay dividends on its common shares. The consequences of CML's borrowing activities to CML and to the holders of common shares, include: (i) limiting CML's ability to obtain additional financing for working capital; (ii) a portion of CML's cash flow from operations will be dedicated for the payment of the interest on its indebtedness; and (iii) certain of CML's borrowings may be at variable rates of interest, exposing CML to the risk of increased interest rates. CML's ability to make scheduled payments of interest on, or to refinance, its indebtedness, will depend on its future cash flow, which is subject to the operations of CML's business, prevailing economic conditions, prevailing interest rate levels, and financial, competitive, business and other factors, many of which are beyond its control. These factors might inhibit CML from refinancing the indebtedness on favourable terms, or at all.

The Credit Agreement contains restrictive covenants that limit the discretion of CML's management with respect to numerous aspects of the business of CML and may, in certain circumstances, restrict CML's ability to pay dividends on its common shares. These covenants place restrictions on, among other things, the ability of CML to incur additional indebtedness, to make loans or advances to, or investments in, any other person, to create security interests to complete mergers, amalgamations, and acquisitions, to pay dividends or make certain other payments, investments, loans, and guarantees and to sell or otherwise dispose of assets. In addition, the Credit Agreement includes financial covenants requiring the borrower to satisfy financial ratios. A failure of CML to comply with its obligations under the Credit Agreement or with respect to other future indebtedness, which could be secured or unsecured, could result in an event of default which, if not cured or waived, could permit the acceleration of the relevant indebtedness. If any indebtedness is so accelerated, there can be no assurance that CML's assets would be sufficient to repay in full the indebtedness. If CML is not able to meet its future debt service obligations, it risks the loss of some or all of its assets to foreclosure, sale, litigation, or other proceedings that could involve the assets of CML. In such circumstances, there can also be no assurance that the credit facilities would be able to be refinanced.

Capital Investment

The timing and amount of capital expenditures by CML will directly affect the amount of cash available for dividends to shareholders. Dividends may be reduced, or even eliminated, at times when the Board of Directors of CML deems it necessary to make significant capital or other expenditures.

Tax Related Risks

The income of CML will be taxed in accordance with Canadian and U.S. tax laws, any of which may be changed in a manner that could adversely affect the amount of cash available to pay dividends to shareholders.

Unpredictability and Volatility of Price of Common Shares

The prices at which the common shares of CML will trade cannot be predicted. The market price of the common shares could be subject to significant fluctuations in response to variations in quarterly operating results, general market conditions, and other factors. The annual yield on the common shares as compared to the annual yield on other financial instruments may also influence the price of common shares in the publicly-traded markets. In addition, the securities markets have experienced significant price and volume fluctuations from time to time in recent years that often have been unrelated or disproportionate to the operating performance of particular issuers. These broad fluctuations may adversely affect the market price of the common shares.

Dilution

CML is authorized to issue an unlimited number of common shares, and subject to certain exceptions, an unlimited number of preferred shares for such consideration and on such terms and conditions as are established by the Board of Directors, without the approval of any shareholders. Further issuances of common shares will dilute the interests of existing shareholders.

Future Sales of Common Shares

Sales of a substantial number of common shares in the public market or otherwise could adversely affect the prevailing market prices of the common shares and could impair CML's ability to raise additional capital through an offering of its equity securities.

DIRECTORS AND EXECUTIVE OFFICERS

Directors and Executive Officers

The following table sets out the name, province or state of residence of each of the directors of CML and indicates their principal occupations within the five preceding years. The table below also indicates the date upon which each director was elected or appointed as a trustee of the Fund, and a director of CML Healthcare Inc. prior to the Arrangement, each of whom became a director of CML upon completion of the Arrangement and will hold office until the first annual meeting of CML's shareholders or until their respective successors have been duly elected or appointed, subject to their earlier resignation or removal.

Name	Principal Occupations Within Five Preceding Years	Date of Election/ Appointment
Gery J. Barry (1)(2)(3) Connecticut, U.S.	Mr. Barry is currently President of MedImpact International, LLC, a company which offers quality management expertise and software to both healthcare providers and payors in overseas markets. Prior thereto, Mr. Barry had established a successful consulting practice, Barry-Global Strategic Services, a firm offering expertise in health insurance and health care quality management. Previously, Mr. Barry was Chief Strategy Officer of Aetna, Inc. (NYSE: AET), a leading U.S. based provider of health care, dental, pharmacy, group life, and disability insurance, and employee benefits. Prior to Aetna, Mr. Barry was President and Chief Executive Officer of Blue Cross and Blue Shield of Louisiana, a mutual insurance company providing group and individual health and medical benefits to more than one million members. Prior thereto, Mr. Barry was President and Chief Executive Officer of Liberty Health (formerly Ontario Blue Cross). Mr. Barry has been a member of the Louisiana HealthCare Quality Forum Board of Directors since its inception, and serves on its Executive Committee. He also serves on the Board of Directors of GroupWorks Inc. (TSX-V: GWC).	August 6, 2009
Steven W. Chepa, C.A.(1)(2)(3) Ontario, Canada	Mr. Chepa, an alumnus of PricewaterhouseCoopers LLP, is the founder and President of Norstone Financial Corporation. Prior to the establishment of Norstone Financial Corporation in 1993, Mr. Chepa was the co-founder and President and Chief Executive Officer of Disys Corporation from 1974 to 1993. Mr. Chepa is a former director of Glendale Corporation, BIOSCRIPT Inc., Cipher Pharmaceuticals Inc., as well as a number of privately-owned corporations. Mr. Chepa is a former governor of Holy Trinity School. He is now Chairman of the World Academy of Rusyn Culture.	February 19, 2004
Dr. Joseph Fairbrother(1)(2)(3) Ontario, Canada	Dr. Fairbrother currently serves as Corporate Chief and Medical Director of Diagnostic Imaging at the William Osler Health System in Brampton, Ontario. Prior to joining the William Osler Health System, Dr. Fairbrother practiced at Hamilton Health Services for over 16 years. He was formerly Assistant Clinical Professor of Radiology at McMaster University, Faculty of Sciences, Hamilton, Ontario. He was also formerly the Chief Financial Officer of Barton Radiology and Wentworth X-Ray Associates.	May 24, 2007

Name	Principal Occupations Within Five Preceding Years	Date of Election/ Appointment
Robert P. Fisher Jr. (1)(2)(3) New York, U.S.	Mr. Fisher has been the President of George F. Fisher, Inc., a private investment company that manages a portfolio of public and private investments, since 2002. Prior to that time, Mr. Fisher held various positions with Goldman, Sachs & Co. in New York, ultimately serving as Managing Director and head of its Canadian Corporate Finance and Canadian Investment Banking units for eight years.	May 6, 2010
Patrice E. Merrin(1)(2)(3) Ontario, Canada (Chairman)	Patrice E. Merrin is Chairman of the Board. Ms. Merrin is an independent consultant and corporate director. She was President and Chief Executive Officer and Director of Luscar Ltd., Canada's largest producer of thermal coal, from 2005 to 2006, having been Executive Vice President since 2004; during her tenure, Luscar was owned equally by Sherritt International Corporation (TSX:S) and Ontario Teachers' Pension Plan Board. From 1999 to 2004, Ms. Merrin was Executive Vice President and Chief Operating Officer of Sherritt International, of which she had been an officer since 1994. She is a director of Enssolutions Group Inc. (TSXV:ENV) and of the Climate Change and Emissions Management Corporation. Ms. Merrin was a Director of The NB Power Group of Companies from 2007 to 2009. She was a member of the National Advisory Panel on Sustainable Energy Science & Technology 2005-2006, and from 2003-2006 was a member of the National Round Table on the Environment and the Economy. She holds a Bachelor of Arts degree from Queen's University and completed the Advanced Management Programme at INSEAD.	March 27, 2008
Dr. John D. Mull Ontario, Canada	Dr. Mull is the founder of CML. Until his retirement on August 8, 2006, Dr. Mull provided daily leadership and played an active role in the technical and operational aspects of CML, as Chief Executive Officer. Dr. Mull also serves as a director of Cipher Pharmaceuticals Inc.	February 19, 2004
Stephen R. Wiseman, C.A.(1)(2)(3) Ontario, Canada	Mr. Wiseman is a former Chairman of the Board. He recently retired as a Senior Partner of Taylor Leibow LLP, the largest independent accounting firm in the greater Hamilton and Burlington region. Prior to joining Taylor Leibow LLP in 1976, Mr. Wiseman held academic positions at McMaster University, the University of Saskatchewan and the University of Ottawa.	May 17, 2005

Notes:

(1) Member of the Audit Committee.

(2) Member of the Nominating and Corporate Governance Committee.

(3) Member of the Compensation Committee.

From June 20, 2008 until his resignation on January 30, 2009, Mr. Chepa was a director of Starwood Flooring Inc., a private company, which made a voluntary assignment in bankruptcy on February 18, 2009.

The following table sets out the name, province of residence and position held of each of the executive officers of CML prior to the completion of the Arrangement, each of whom continue to hold such positions as of the date of this Annual Information Form.

Name and Residency	Position
Paul J. Bristow Ontario, Canada	President and Chief Executive Officer
Tom S. Weber [(1)] Ontario, Canada	Executive Vice President and Chief Financial Officer
Kent B. Nicholson[(2)] Ontario, Canada	Executive Vice President and Chief Operating Officer

Notes:

(1) Prior to joining CML in January 2006, Mr. Weber was Chief Financial Officer of St. Joseph Communications.

(2) Prior to joining CML in October 2007, Mr. Nicholson was the Divisional Vice President, Petroleum Operations and Business Development of Canadian Tire Corporation.

As at December 31, 2010, the directors and executive officers of CML, as a group, beneficially owned, directly or indirectly, or exercised control or direction over an aggregate of 394,542 trust units of the Fund, which, upon completion of the Arrangement, effectively became common shares of CML, representing approximately 4.37% of the outstanding common shares of CML.

Audit Committee

Upon completion of the Arrangement, the Audit Committee of the Fund became the Audit Committee of CML. The Audit Committee of CML is responsible for the oversight and supervision of CML's accounting and financial reporting practices and procedures, the adequacy of internal accounting controls and procedures, and the quality and integrity of financial statements. In addition, the Audit Committee is responsible for directing the auditors' examination into specific areas.

Education and Experience

As at December 31, 2010, the Audit Committee of the Fund was composed of the following persons, each of whom became members of the Audit Committee of CML upon completion of the Arrangement. The education and experience of each Audit Committee member that is relevant to such members' responsibilities as a member of the Audit Committee are also set out below.

Name	Relevant Education and Experience
Stephen R. Wiseman, C.A. (Chair)	Mr. Wiseman has recently retired as a Senior Partner of Taylor Leibow LLP, the largest independent accounting firm in the greater Hamilton and Burlington region. Mr. Wiseman is a member of the Canadian Institute of Chartered Accountants and the Institute of Chartered Accountants of Ontario. Mr. Wiseman also holds a C.M.A. designation from the Society of Management Accountants, and a C.F.E. designation from the Association of Certified Fraud Examiners. Prior to joining Taylor Leibow LLP in 1976, Mr. Wiseman held academic positions at McMaster University, the University of Saskatchewan, and the University of Ottawa. He earned his MBA from McMaster University and Bachelor of Commerce and Master of Arts (Economics) degrees from the University of Ottawa. Mr. Wiseman was CML's auditor prior to CML going public in 1996, and was involved with CML as both financial and business advisor during CML's growth period leading up to its initial public offering.

Name	Relevant Education and Experience
Gery J. Barry	Mr. Barry is currently President of MedImpact International, LLC, a company which offers quality management expertise and software to both healthcare providers and payors in overseas markets. Prior thereto, he was President and CEO of Barry-Global Strategic Services, a firm offering expertise in health insurance and health care quality management. He most recently served as Chief Strategy Officer of Aetna, Inc. (NYSE: AET), a leading U.S.-based provider of health care, dental, pharmacy, group life, and disability insurance, and employee benefits. Prior to Aetna, Mr. Barry was President and Chief Executive Officer of Blue Cross and Blue Shield of Louisiana, a mutual insurance company providing group and individual health and medical benefits to more than one million members. Prior thereto, Mr. Barry has been a member of the Louisiana HealthCare Quality Forum Board of Directors since its inception and serves on its Executive Committee. He also serves on the Board of Directors of Group Works Inc. (TSX-V: GWC). Mr. Barry holds a Bachelor of Science (Honors Mathematics) from the University of Notre Dame, and a Masters Degree (Applied Mathematics) from Rutgers University. He is a Fellow of the Society of Actuaries.
Steven W. Chepa, C.A.	Mr. Chepa, an alumnus of PricewaterhouseCoopers LLP, is the founder and President of Norstone Financial Corporation. Prior to the establishment of Norstone Financial Corporation in 1993, Mr. Chepa was the co-founder and President and Chief Executive Officer of Disys Corporation from 1974 to 1993. Mr. Chepa is a former director of Glendale Corporation, BIOSCRIPT Inc., Cipher Pharmaceuticals Inc., as well as a number of privately-owned corporations. Mr. Chepa is a former governor of Holy Trinity School. He is now Chairman of the World Academy of Rusyn Culture.
Dr. Joseph Fairbrother	Dr. Fairbrother currently serves as Corporate Chief and Medical Director of Diagnostic Imaging at the William Osler Health System in Brampton, Ontario. Prior to joining the William Osler Health System, Dr. Fairbrother practiced at Hamilton Health Services for over 16 years. He was formerly Assistant Clinical Professor of Radiology at McMaster University, Faculty of Sciences, Hamilton, Ontario. He was also formerly the Chief Financial Officer of Barton Radiology and Wentworth X-Ray Associates.
Robert P. Fisher, Jr.	Mr. Fisher has been the President of George P. Fisher, Inc., a private investment company that manages a portfolio of public and private investments, since 2002. Prior to that time, Mr. Fisher held various positions with Goldman, Sachs & Co. in New York for 19 years, eventually serving as Managing Director and head of its Canadian Corporate Finance and Canadian Investment Banking units for eight years. During his time at Goldman Sachs, Mr. Fisher was responsible, among other things, for managing a group of investment banking professionals dedicated to servicing Goldman Sachs' Canadian corporate clients. Mr. Fisher has been involved in numerous initial public offerings of equity and debt securities, mergers and acquisitions, privatizations and financial recapitalizations for U.S., Canadian, and international corporations and government agencies. Mr. Fisher was the only U.S. investment banker invited by the Ontario Securities Commission to serve on an advisory panel to establish the Canada/U.S. Multi-Jurisdictional Disclosure System. Mr. Fisher holds a Bachelor of Arts in Economics and History from Dartmouth College and a Masters Degree of Arts in Law and Diplomacy from The Fletcher School at Tufts University.
Patrice E. Merrin	Ms. Merrin is the Chairman of the Board of CML. Ms. Merrin, a consultant, is also President and Chief Executive Officer of Patrice Merrin & Partners. She was President and CEO and Director of Luscar Ltd., Canada's largest producer of thermal coal, from 2005 to 2006, prior to which she was Executive Vice-President. From 1994 to 2004, Ms. Merrin was an officer of Sherritt International Corporation, serving as Executive Vice-President and COO from 1999 to 2004. Ms. Merrin is a director of Enssolutions Group Inc. and of the Climate Change and Emissions Management Corporation. She holds a Bachelor of Arts degree from Queen's University and completed the Advanced Management Programme at INSEAD.

The Board of Directors of CML has determined that each member of the Audit Committee is independent and financially literate. Independent means free from any direct or indirect material relationship with CML which, in the view of the Board, could reasonably interfere with the exercise of a member's independent judgment as more particularly described in National Instrument 52-110 – *Audit Committees*. Financially literate means having the ability to read and understand a set of financial statements that present a breadth and level of complexity of

accounting issues that are generally comparable to the breadth and complexity of the issues that can reasonably be expected to be raised by the Fund's and CML's financial statements.

Audit Committee Charter

Set forth as Schedule A to this Annual Information Form is the full text of the Charter of the Audit Committee of CML.

Audit Committee Oversight

At no time during the Fund's most recently completed fiscal year was a recommendation of the Audit Committee of the Fund to nominate or compensate an external auditor not adopted by the Board of Trustees.

Pre-approval Policies and Procedures

The Audit Committee of the Fund approved (and the Audit Committee of CML will now approve), on a case by case basis, all non-audit services provided to the Fund and its subsidiaries by its external auditors, PricewaterhouseCoopers LLP.

External Auditor Service Fees (By Category)

The fees paid or payable by the Fund and CML to PricewaterhouseCoopers LLP, the Fund's and CML's external auditors, for the periods noted below for audit and non-audit services were as follows:

	2009	**2010**
PricewaterhouseCoopers LLP		
Audit Fees(1)	$581,866	$680,749
Audit-Related Fees(2)	$39,690	$207,085
Tax Fees(3)	$177,127	$400,187
All Other Fees(4)	$8,238	$10,466
Total	**$806,921**	**$1,298,487**

(1) This category is intended to capture all fees in respect of services performed in order to comply with Canadian generally accepted auditing standards ("**GAAS**"). In some cases, these may include an appropriate allocation of fees for tax services or accounting consultations, to the extent such services were necessary to comply with GAAS.

(2) This category generally consists of fees in respect of assurance and related services reasonably related to the performance of the audit or review of the financial statements not reported under "audit fees". Included are such things as employee benefit plan audits, due diligence relating to mergers and acquisitions, accounting consultations and audits in connection with acquisitions, internal control reviews, attest services that are not required by statute or regulation, and consultation concerning financial accounting and reporting standards. The audit-related services actually provided by the external auditors in respect of fiscal 2009 and 2010 consisted of due diligence relating to mergers and acquisitions, and accounting consultations relating to IFRS.

(3) This category includes all fees in respect of services performed by the. auditors' tax professionals, except those services required in order to comply with GAAS which are included under "audit fees". Tax services include tax compliance, tax planning and tax advice.

(4) This category captures fees in respect of all services not falling under any of the foregoing three categories.

Nominating and Corporate Governance Committee

Upon completion of the Arrangement, the Nominating and Corporate Governance Committee of the Fund became Nominating and Corporate Governance Committee of CML. The Nominating and Corporate Governance Committee is responsible for developing CML's approach to governance issues, making recommendations to the Board of

Directors with respect to the nomination of directors and periodically reviewing the composition and effectiveness of the directors and the contribution of individual directors.

The Board of Directors have determined that the members of the Nominating and Corporate Governance Committee of CML, being Mr. Chepa (Chair), Mr. Wiseman, Dr, Fairbrother, Ms. Merrin, Mr. Barry, and Mr. Fisher, are independent.

Compensation Committee

Upon completion of the Arrangement, the Compensation Committee of the Fund became the Compensation Committee of CML. The Compensation Committee is directly responsible for developing CML's approach to compensation issues, including the following:

- reviewing and approving compensation of CML's Chief Executive Officer;
- recommending to the Board of Directors non-Chief Executive Officer compensation, incentive-based plans, and equity-based plans; and
- reviewing compensation disclosure in public documents.

The Board of Directors have determined that the members of the Compensation Committee, being Ms. Merrin (Chair), Mr. Chepa, Mr. Wiseman, Dr. Fairbrother, Mr. Barry, and Mr. Fisher, are independent.

DIVIDEND RECORD AND POLICY

During the year ended December 31, 2010, the Fund paid monthly cash distributions on the outstanding trust units of $0.08927 per month.

From January 1, 2009 to December 31, 2009, the Fund made cash distributions to unitholders totalling $1.07124 per trust unit. In 2008 the Fund made cash distributions to unitholders totalling $1.05916 per trust unit.

While the Board of Directors of CML currently anticipates a monthly dividend of $0.0629 per common share, there can be no guarantee the current policy will be maintained. As a corporation, CML's dividend policy is subject to the discretion of its Board of Directors. Future dividends, if any, will depend on the operations and assets of CML and will be subject to various factors, including, without limitation, CML's earnings, financial requirements, the satisfaction of solvency tests imposed by the *Business Corporations Act* (Ontario) for the declaration of dividends and other factors that the directors may deem relevant from time to time.

DESCRIPTION OF CAPITAL STRUCTURE

The authorized capital of CML consist of an unlimited number of common shares and an unlimited number of preferred shares issuable in series, of which 89,842,397 common shares and no preferred shares were issued and outstanding as at the date of this Annual Information Form. The following is a summary of the rights, privileges, restrictions and conditions attaching to the securities which comprise the authorized capital of CML.

Common Shares

Holders of common shares are entitled to one vote per share at meetings of shareholders of CML; to receive dividends if, as, and when declared by the Board of Directors of CML; and to receive *pro rata* the remaining property and assets of CML upon its dissolution or winding-up, subject to the rights of shares having priority over the common shares. Holders of common shares may make use of the various shareholder remedies available pursuant to the *Business Corporations Act* (Ontario).

Preferred Shares

Each series of preferred shares will consist of such number of shares and having such rights, privileges, restrictions, and conditions as may be determined by the Board of Directors of CML, prior to the issuance thereof, provided that the Board of Directors will not be permitted to issue preferred shares representing 25% or more of the aggregate number of outstanding common shares at any time. Holders of preferred shares, except as required by law, will not be entitled to vote at meetings of shareholders of CML. With respect to the payment of dividends and distribution of assets in the event of liquidation, dissolution, or winding-up of CML, whether voluntary or involuntary, the preferred shares are entitled to preference over the common shares and any other shares ranking junior to the preferred shares from time to time and may also be given such other preferences over the common shares and any other shares ranking junior to the preferred shares as may be determined at the time of creation of such series. The preferred shares have not been created as, and are not intended to be, an anti-takeover mechanism.

MARKET FOR SECURITIES

Market for Securities

The common shares of CML were listed and posted for trading on the Toronto Stock Exchange on January 4, 2011 under the symbol "CLC", at which time the trust units of the Fund were delisted.

Trading Price and Volume

The following tables show the monthly range of high and low prices per trust unit and total monthly volumes traded on the Toronto Stock Exchange during the 12 months ended December 31, 2010.

Month	Price per Unit($) Monthly High	Price per Unit($) Monthly Low	Units Total Monthly Volume
January 2010	14.62	12.91	5,845,687
February 2010	13.68	13.01	3,352,571
March 2010	13.54	11.50	9,816,488
April 2010	12.74	11.11	7,487,292
May 2010	11.58	10.20	5,523,548
June 2010	10.30	9.41	4,876,597
July 2010	10.14	9.56	4,657,473
August 2010	11.20	9.51	9,300,950
September 2010	11.59	11.01	4,087,764
October 2010	12.60	11.28	3,451,015
November 2010	12.45	10.92	4, 317, 600
December 2010	12.25	10.78	6,700,828

Prior Sales

During the year ended December 31, 2010, the Fund did not issue any trust units. Pursuant to the Arrangement, CML effectively issued 89,842,397 common shares in exchange for the equivalent number of trust units of the Fund.

LEGAL PROCEEDINGS AND REGULATORY ACTIONS

CML is not involved in any legal proceeding or regulatory action which would have a material adverse effect on CML on a consolidated basis.

INTEREST OF MANAGEMENT AND OTHERS IN MATERIAL TRANSACTIONS

In the normal course of business, CML leases facilities at market rates from companies that are subject to significant influence or are controlled by Dr. John D. Mull and/or a member of his family. In particular, Dr, John D. Mull and a family member have an indirect interest in the land and premises at 6560 Kennedy Road, Mississauga, Ontario, L5T 2X4 where CML's central laboratory is located. CML's aggregate rent expense for such premises totalled approximately $1,293,000 for the year ended December 31, 2010.

TRANSFER AGENT AND REGISTRAR

The transfer agent and registrar for the common shares is CIBC Mellon Trust Company at its principal office in Toronto, Ontario.

MATERIAL CONTRACTS

There were no material contracts entered into by the Fund or its subsidiaries in 2010, or prior to 2010 which were still in effect on December 31, 2010, other than the Credit Agreement and contracts in the ordinary course of business, or as were terminated in connection with the Arrangement effective January 1, 2011 and as described herein under "Recent Developments – Material Contracts and Other Arrangements".

EXPERTS

The financial statements of the Fund for the year ended December 31, 2010 have been audited by PricewaterhouseCoopers LLP, which is independent in accordance with the auditors' rules of professional conduct in the Province of Ontario.

ADDITIONAL INFORMATION

Additional information relating to CML may be found on the System for Electronic Document Analysis and Retrieval which can be accessed at www.sedar.com. Additional information, including trustees' and directors' and officers' remuneration and indebtedness, principal holders of CML's securities and securities authorized for issuance under equity compensation plans, if applicable, will be contained in CML's information circular for its annual meeting of shareholders to be held on May 19, 2011. Additional financial information is provided in the financial statements and management's discussion and analysis of the Fund for the year ended December 31, 2010.

SCHEDULE A
CHARTER OF THE AUDIT COMMITTEE
OF
CML HEALTHCARE INC.

CML HealthCare
Care. Confidence. Comfort.

CHARTER OF THE AUDIT COMMITTEE
OF
CML HEALTHCARE INC.

GENERAL

1. PURPOSE AND RESPONSIBILITIES OF THE COMMITTEE

1.1 Purpose

The primary purpose of the Committee is to assist Board oversight of:

(a) the integrity of the Corporation's financial statements and of the accounting and financial reporting practices and procedures of the Corporation;

(b) the adequacy of the internal and accounting controls and procedures of the Corporation;

(c) the External Auditor's qualifications and independence;

(d) the performance of the Corporation's internal audit function and the External Auditor; and

(e) the Corporation's compliance with legal and regulatory requirements, to the extent that such requirements are relevant to the foregoing.

2. DEFINITIONS AND INTERPRETATION

2.1 Definitions

In this Charter:

(a) "Board" means the Board of Directors of the Corporation;

(b) "Chair" means the chair of the Committee;

(c) "Committee" means the audit committee of the Board;

(d) "Corporation" means CML HealthCare Inc.;

(e) "Directors" means the directors of the Corporation;

(f) "External Auditor" means the Corporation's independent auditor; and

(g) **"GAAP"** means Canadian generally accepted accounting principles.

Any words or terms with initial capital letters which are not defined herein shall have the meanings ascribed thereto in the charter of the Board.

2.2 Interpretation

The provisions of this Charter are subject to the provisions of the by-laws of the Corporation and any Applicable Laws.

CONSTITUTION AND FUNCTIONING OF THE COMMITTEE

3. ESTABLISHMENT AND COMPOSITION OF THE COMMITTEE

3.1 Establishment of the Audit Committee

The Committee is hereby continued with the constitution, function and responsibilities herein set forth.

3.2 Appointment and Removal of Members of the Committee

(a) Board Appoints Members. The members of the Committee shall be appointed by the Board.

(b) Annual Appointments. The appointment of members of the Committee shall take place annually at the first meeting of the Board after a meeting of the Shareholders at which Directors are elected, provided that if the appointment of members of the Committee is not so made, the Directors who are then serving as members of the Committee shall continue as members of the Committee until their successors are appointed.

(c) Vacancies. The Board may appoint a member to fill a vacancy which occurs in the Committee between annual elections of Directors.

(d) Removal of Member. Any member of the Committee may be removed from the Committee by a resolution of the Board.

3.3 Number of Members

The Committee shall consist of three or more Directors.

3.4 Independence of Members

Each member of the Committee shall be independent as defined under Applicable Laws.

3.5 Financial Literacy

(a) Financial Literacy Requirement. Each member of the Committee shall be financially literate or must become financially literate within a reasonable period of time after his or her appointment to the Committee.

(b) Definition of Financial Literacy. "Financially literate" means the ability to read and understand a set of financial statements that present a breadth and level of complexity of accounting issues that are generally comparable to the breadth and complexity of the issues that can reasonably be expected to be raised by the Corporation's financial statements.

3.6 Audit Committee Financial Expert

(a) Attributes of an Audit Committee Financial Expert. To the extent possible, the Board will appoint to the Committee at least one Director who has the following attributes:

(i) an understanding of generally accepted accounting principles and financial statements;

(ii) ability to assess the general application of such principles in connection with the accounting for estimates, accruals and reserves;

(iii) experience preparing, auditing, analyzing or evaluating financial statements that present a breadth and level of complexity of accounting issues that are generally comparable to the breadth and complexity of issues that can reasonably be expected to be raised by the Corporation's financial statements, or experience actively supervising one or more persons engaged in such activities;

(iv) an understanding of internal controls and procedures for financial reporting; and

(v) an understanding of audit committee functions.

(b) Experience of the Audit Committee Financial Expert. To the extent possible, the Board will appoint to the Committee at least one Director who acquired the attributes in (a) above through:

(i) education and experience as a principal financial officer, principal accounting officer, controller, public accountant or auditor or experience in one or more positions that involve the performance of similar functions (or such other qualification as the Board interprets such qualification in its business judgment);

(ii) experience actively supervising a principal financial officer, principal accounting officer, controller, public accountant, auditor or person performing similar functions;

(iii) experience overseeing or assessing the performance of companies or public accountants with respect to the preparation, auditing or evaluation of financial statements; or

(iv) other relevant experience.

4. COMMITTEE CHAIR

4.1 Board to Appoint Chair

The Board shall appoint the Chair from the members of the Committee (or, if it fails to do so, the members of the Committee shall appoint the Chair from among its members).

4.2 Chair to be Appointed Annually

The designation of the Committee's Chair shall take place annually at the first meeting of the Board after a meeting of Shareholders at which Directors are elected, provided that if the designation of Chair is not so made, the Director who is then serving as Chair shall continue as Chair until his or her successor is appointed.

5. COMMITTEE MEETINGS

5.1 Quorum

A quorum of the Committee shall be a majority of its members.

5.2 Secretary

The Chair shall designate from time to time a person who may, but need not, be a member of the Committee, to be Secretary of the Committee.

5.3 Time and Place of Meetings

The time and place of the meetings of the Committee and the calling of meetings and the procedure in all things at such meetings shall be determined by the Committee; provided, however, the Committee shall meet at least quarterly. Subject to the Corporation's by-laws, Directors shall receive 48 hours notice of any meeting of the Committee.

5.4 In Camera Meetings

As part of each meeting of the Committee at which the Committee recommends that the Board approve the annual audited financial statements or at which the Committee approves the quarterly financial statements, the Committee shall meet separately with each of:

(a) management;

(b) the External Auditor; and

(c) the internal auditor, if any.

5.5 Right to Vote

Each member of the Committee shall have the right to vote on matters that come before the Committee.

5.6 Invitees

The Committee may Directors, officers and employees of the Corporation or any other person to attend meetings of the Committee to assist in the discussion and examination of the matters under consideration by the Committee. The External Auditor shall receive notice of each meeting of the Committee and shall be entitled to attend any such meeting at the Corporation's expense.

5.7 Regular Reporting

The Committee shall report to the Board at the Board's next meeting the proceedings at the meetings of the Committee and all recommendations made by the Committee at such meetings.

6. AUTHORITY OF COMMITTEE

6.1 Retaining and Compensating Advisors

The Committee shall have the authority to engage independent counsel and other advisors as the Committee may deem appropriate in its sole discretion and to set and pay the compensation for any advisors employed by the Committee. The Committee shall not be required to obtain the approval of the Board in order to retain or compensate such consultants or advisors.

6.2 Subcommittees

The Committee may form and delegate authority to subcommittees if deemed appropriate by the Committee.

6.3 Recommendations to the Board

The Committee shall have the authority to make recommendations to the Board, but shall have no decision-making authority other than as specifically contemplated in this Charter.

7. REMUNERATION OF COMMITTEE MEMBERS

7.1 Remuneration of Committee Members

Members of the Committee and the Chair shall receive such remuneration for their service on the Committee as the Board may determine from time to time.

7.2 Trustees' Fees

No member of the Committee may earn fees from the Corporation or any of its subsidiaries other than Directors' fees (which fees may include cash and/or securities or options or other in-kind consideration ordinarily available to Directors, as well as all of the regular benefits that other Directors receive). For greater certainty, no member of the Committee shall accept, directly or indirectly, any consulting, advisory or other compensatory fee from the Corporation or any of its subsidiaries.

SPECIFIC DUTIES AND RESPONSIBILITIES

8. INTEGRITY OF FINANCIAL STATEMENTS

8.1 Review and Approval of Financial Information

(a) Annual Financial Statements. The Committee shall review and discuss with management and the External Auditor the Corporation's audited annual financial statements and related MD&A together with the report of the External Auditor thereon and, when appropriate, shall recommend to the Board that the Board approve the audited annual financial statements.

(b) Interim Financial Statements. The Committee shall review and discuss with management and the External Auditor and, when appropriate, shall recommend to the Board that the Board approve the Corporation's interim unaudited financial statements and related MD&A.

(c) Material Public Financial Disclosure. The Committee shall discuss with management and the External Auditor:

(i) the types of information to be disclosed, and the type of presentation to be made, in connection with earnings press releases,

(ii) financial information and earnings guidance (if any) to be provided to analysts, investors and rating agencies, and

(iii) press releases containing financial information (paying particular attention to any use of "pro forma" or "adjusted" non-GAAP information),

and, when appropriate, shall recommend to the Board that the Board approve any such material financial disclosure prior to its release to the public.

(d) Procedures for Review. The Committee shall be satisfied that adequate procedures are in place for the review of the Corporation's disclosure of financial information extracted or derived from the Corporation's financial statements (other than financial statements, MD&A and earnings press releases, which are dealt with elsewhere in this Charter) and shall periodically assess the adequacy of those procedures.

(e) Accounting Treatment. The Committee shall review and dscuss with management and the External Auditor:

(i) major issues regarding accounting principles and financial statement presentations including any significant changes in the Corporation's selection or application of

accounting principles and major issues as to the adequacy of the Corporation's internal controls and any special audit steps adopted in light of material control deficiencies;

(ii) analyses prepared by management and/or the External Auditor setting forth significant financial reporting issues and judgments made in connection with the preparation of the financial statements, including analyses of the effects of alternative GAAP methods on the financial statements;

(iii) the effect of regulatory and accounting initiatives, as well as off-balance sheet structures, on the Corporation's financial statements;

(iv) the management certifications of the financial statements as required by applicable securities laws in Canada or otherwise; and

(v) pension plan financial statements, if any.

9. EXTERNAL AUDITOR

9.1 External Auditor

(a) Authority with Respect to External Auditor. As a representative of the Corporation's Shareholders, the Committee shall be directly responsible for the nomination, compensation and oversight of the work of the External Auditor engaged for the purpose of preparing or issuing an audit report or performing other audit, review or attest services for the Corporation. In the discharge of this responsibility, the Committee shall:

(i) have sole responsibility for recommending to the Board the person to be proposed to the Corporation's Shareholders for appointment as External Auditor for the above-described purposes as well as the responsibility for recommending such External Auditor's compensation and determining at any time whether the Board should recommend to the Corporation's Shareholders whether the incumbent External Auditor should be removed from office;

(ii) review the terms of the External Auditor's engagement, discuss the audit fees with the External Auditor and be solely responsible for approving such audit fees; and

(iii) require the External Auditor to confirm in its engagement letter each year that the External Auditor is accountable to, and shall report directly to, the Committee as the representative of unitholders.

(b) Independence. The Committee shall satisfy itself as to the independence of the External Auditor. As part of this process the Committee shall:

(i) assure the regular rotation of the lead audit partner as required by law and consider whether, in order to ensure continuing independence of the External Auditor, the Corporation should rotate periodically, the audit firm that serves as External Auditor;

(ii) require the External Auditor to submit on a periodic basis to the Committee a formal written statement delineating all relationships between the External Auditor and the Corporation and its subsidiaries and that the Committee is responsible for actively engaging in a dialogue with the External Auditor with respect to any disclosed relationships or services that may impact the objectivity and independence of the External Auditor and for recommending that the Board take appropriate action in response to the External Auditor's report to satisfy itself of the External Auditor's independence;

(iii) address non-audit services provided by the External Auditor as described in clause (d) below; and

(iv) review and approve the policy setting out the restrictions on the Corporation and its subsidiaries hiring partners, employees and former partners and employees of the Corporation's current or former External Auditor.

(c) Issues Between External Auditor and Management. The Committee shall:

(i) review any problems experienced by the External Auditor in conducting the audit, including any restrictions on the scope of the External Auditor's activities or in access to requested information;

(ii) review any disagreements with management and, to the extent possible, resolve any disagreements between management and the External Auditor regarding financial reporting; and

(iii) review with the External Auditor:

(A) any accounting adjustments that were proposed by the External Auditor, but were not made by management;

(B) any communications between the audit team and audit firm's national office respecting significant auditing or accounting issues presented by the engagement;

(C) any management or internal control letter issued, or proposed to be issued, by the External Auditor to the Corporation; and

(D) the performance of the Corporation's internal audit function and internal auditors.

(d) Non-Audit Services.

(i) The Committee shall either:

(A) approve any non-audit services provided by the External Auditor or the external auditor of any subsidiary of the Corporation to the Corporation (including its subsidiaries); or

(B) adopt specific policies and procedures for the engagement of non-audit services, provided that such pre-approval policies and procedures are detailed as to the particular service, the Committee is informed of each non-audit service and the procedures do not include delegation of the Committee's responsibilities to management.

(ii) The Committee may delegate to one or more members of the Committee the authority to pre-approve non-audit services in satisfaction of the requirement in the previous section, provided that such member or members must present any non-audit services so approved to the full Committee at its first scheduled meeting following such pre-approval.

(iii) The Committee shall instruct management to promptly bring to its attention any services performed by the External Auditor which were not recognized by the Corporation at the time of the engagement as being non-audit services.

(e) Evaluation of External Auditor. The Committee shall evaluate the External Auditor each year, and present its conclusions to the Board. In connection with this evaluation, the Committee shall:

(i) review and evaluate the performance of the lead partner of the External Auditor;

(ii) obtain the opinions of management and of the persons responsible for the Corporation's internal audit function with respect to the performance of the External Auditor; and

(iii) obtain and review a report by the External Auditor describing:

(A) the External Auditor's internal quality-control procedures;

(B) to the extent permitted by Applicable Laws and by the Canadian Public Accountability Board, any material issues raised by the most recent internal quality-control review, or peer review, of the External Auditor's firm or by any inquiry or investigation by governmental or professional authorities, within the preceding five years, respecting one or more independent audits carried out by the External Auditor's firm, and any steps taken to deal with any such issues; and

(C) all relationships between the External Auditor and the Corporation (for the purposes of assessing the External Auditor's independence).

(f) Review of Management's Evaluation and Response. The Committee shall:

(i) review management's evaluation of the External Auditor's audit performance;

(ii) review the External Auditor's recommendations, and review management's response to, and subsequent follow-up on, any identified weaknesses;

(iii) review management's response to significant internal control recommendations of the internal audit staff and the External Auditor;

(iv) receive regular reports from management and receive comments from the External Auditor, if any, on:

(A) the Corporation's principal financial risks;

(B) the systems implemented to monitor those risks; and

(C) the strategies (including hedging strategies) in place to manage those risks; and

(g) recommend to the Board whether any new material strategies presented by management should be considered appropriate and approved.

10. INTERNAL AUDIT FUNCTION*

10.1 Internal Auditor[1]

In connection with the Corporation's internal audit function, the Committee shall:

(a) review the terms of reference of the internal auditor, if any, and meet with the internal auditor as the Committee may consider appropriate to discuss any concerns or issues;

(b) in consultation with the External Auditor and the internal audit group, review the adequacy of the Corporation's internal control structure and procedures designed to ensure compliance with laws and regulations and any special audit steps adopted in light of material deficiencies and controls;

(c) review the internal control report prepared by management, including management's assessment of the effectiveness of the Corporation's internal control structure and procedures for financial reporting; and

(d) periodically review with the internal auditor any significant difficulties, disagreements with management or scope restrictions encountered in the course of the work of the internal auditor.

11. COMPLIANCE WITH LEGAL AND REGULATORY REQUIREMENTS

11.1 Risk Assessment and Risk Management

The Committee shall discuss the Corporation's major financial risk exposures and the steps management has taken to monitor and control such exposures and shall report to the Board with respect thereto.

11.2 Related Party Transactions

The Committee shall review and approve all related party transactions in which the Corporation is involved or which the Corporation proposes to enter into.

11.3 Whistleblowing Policy

The Committee shall put in place, subject to approval by the Board, procedures for:

(a) the receipt, retention and treatment of complaints received by the Corporation or its subsidiaries regarding accounting, internal accounting controls or auditing matters; and

(b) the confidential, anonymous submission by employees of the Corporation or its subsidiaries of concerns regarding questionable accounting or auditing matters.

12. ANNUAL PERFORMANCE REVIEW

On an annual basis, the Committee shall follow the process established by the Board and overseen by the Nominating and Corporate Governance Committee for reviewing the performance of the Committee.

---

[1] Internal Audit resides with the Process Design and Control Department. The Internal Auditor referred to throughout this document is the Director, Process Design and Control.

13. CHARTER REVIEW

The Committee shall review and assess the adequacy of this Charter annually and recommend to the Board any changes it deems appropriate.

14. EFFECTIVE DATE

This Charter was approved the Board as of January 1, 2011, including all members of the Audit Committee. Any amendments to this Charter require the specific approval of the Audit Committee.