TENET HEALTHCARE CORP
Form 10-Q
May 02, 2016
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-Q

Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
for the quarterly period ended March 31, 2016

OR

Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
for the transition period from to

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

Nevada	95-2557091
(State of Incorporation)	(IRS Employer Identification No.)

1445 Ross Avenue, Suite 1400
Dallas, TX 75202

(Address of principal executive offices, including zip code)

(469) 893-2200

(Registrant's telephone number, including area code)

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months, and (2) has been subject to such filing requirements for the past 90 days. Yes No

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes No

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Exchange Act Rule 12b-2).

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company

Indicate by check mark whether the Registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes No

At April 27, 2016, there were 99,304,410 shares of the Registrant's common stock, $0.05 par value, outstanding.

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PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

Dollars in Millions

(Unaudited)

	March 31, 2016	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 728	$ 356
Accounts receivable, less allowance for doubtful accounts ($901 at March 31, 2016 and $887 at December 31, 2015)	2,807	2,704
Inventories of supplies, at cost	312	309
Income tax receivable	—	7
Assets held for sale	2	550
Other current assets	1,280	1,245
Total current assets	5,129	5,171
Investments and other assets	1,142	1,175
Deferred income taxes	726	776
Property and equipment, at cost, less accumulated depreciation and amortization ($4,538 at March 31, 2016 and $4,323 at December 31, 2015)	7,961	7,915
Goodwill	7,122	6,970
Other intangible assets, at cost, less accumulated amortization ($701 at March 31, 2016 and $659 at December 31, 2015)	1,686	1,675
Total assets	$ 23,766	$ 23,682
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 172	$ 127
Accounts payable	1,228	1,380
Accrued compensation and benefits	772	880
Professional and general liability reserves	161	177
Accrued interest payable	307	205
Liabilities held for sale	—	101
Accrued legal settlement costs	423	294
Other current liabilities	1,205	1,144

Total current liabilities	4,268	4,308
Long-term debt, net of current portion	14,350	14,383
Professional and general liability reserves	623	578
Defined benefit plan obligations	593	595
Other long-term liabilities	625	594
Total liabilities	20,459	20,458
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	2,381	2,266
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 147,692,493 shares issued at March 31, 2016 and 146,920,454 shares issued at December 31, 2015	7	7
Additional paid-in capital	4,804	4,815
Accumulated other comprehensive loss	(160)	(164)
Accumulated deficit	(1,609)	(1,550)
Common stock in treasury, at cost, 48,424,273 shares at March 31, 2016 and 48,425,298 shares at December 31, 2015	(2,417)	(2,417)
Total shareholders' equity	625	691
Noncontrolling interests	301	267
Total equity	926	958
Total liabilities and equity	$ 23,766	$ 23,682

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Dollars in Millions, Except Per-Share Amounts

(Unaudited)

	Three Months Ended March 31,	
	2016	2015
Net operating revenues:		
Net operating revenues before provision for doubtful accounts	$ 5,420	$ 4,787
Less: Provision for doubtful accounts	376	363
Net operating revenues	5,044	4,424
Equity in earnings of unconsolidated affiliates	24	4
Operating expenses:		
Salaries, wages and benefits	2,402	2,125
Supplies	811	687
Other operating expenses, net	1,242	1,093
Electronic health record incentives	—	(6)
Depreciation and amortization	212	207
Impairment and restructuring charges, and acquisition-related costs	28	29
Litigation and investigation costs	173	3
Gains on sales, consolidation and deconsolidation of facilities	(147)	—
Operating income	347	290
Interest expense	(243)	(199)
Investment earnings	1	—
Net income from continuing operations, before income taxes	105	91
Income tax expense	(67)	(16)
Net income from continuing operations, before discontinued operations	38	75
Discontinued operations:		
Loss from operations	(5)	(1)
Litigation and investigation costs	—	3
Income tax benefit (expense)	1	(1)
Net income (loss) from discontinued operations	(4)	1
Net income	34	76
Less: Net income attributable to noncontrolling interests	93	29
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (59)	$ 47
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders		
Net income (loss) from continuing operations, net of tax	$ (55)	$ 46
Net income (loss) from discontinued operations, net of tax	(4)	1
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (59)	$ 47

Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:		
Basic		
Continuing operations	$ (0.56)	$ 0.47
Discontinued operations	(0.04)	0.01
	$ (0.60)	$ 0.48
Diluted		
Continuing operations	$ (0.56)	$ 0.46
Discontinued operations	(0.04)	0.01
	$ (0.60)	$ 0.47
Weighted average shares and dilutive securities outstanding (in thousands):		
Basic	98,768	98,699
Diluted	98,768	100,872

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME

Dollars in Millions

(Unaudited)

	Three Months Ended March 31,	
	2016	2015
Net income	$ 34	$ 76
Other comprehensive income:		
Amortization of net actuarial loss included in net periodic benefit costs	—	3
Unrealized gains on securities held as available-for-sale	3	1
Foreign currency translation adjustments	2	—
Other comprehensive income before income taxes	5	4
Income tax expense related to items of other comprehensive income	(1)	(1)
Total other comprehensive income, net of tax	4	3
Comprehensive net income	38	79
Less: Comprehensive income attributable to noncontrolling interests	93	29
Comprehensive net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (55)	$ 50

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Dollars in Millions

(Unaudited)

	Three Months Ended March 31,	
	2016	2015
Net income	$ 34	$ 76
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	212	207
Provision for doubtful accounts	376	363
Deferred income tax expense	31	12
Stock-based compensation expense	16	15
Impairment and restructuring charges, and acquisition-related costs	28	29
Litigation and investigation costs	173	3
Gains on sales, consolidation and deconsolidation of facilities	(147)	—
Equity in earnings of unconsolidated affiliates, net of distributions received	12	(4)
Amortization of debt discount and debt issuance costs	10	7
Pre-tax loss (income) from discontinued operations	5	(2)
Other items, net	2	(4)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(453)	(484)
Inventories and other current assets	(18)	(74)
Income taxes	28	8
Accounts payable, accrued expenses and other current liabilities	(114)	(200)
Other long-term liabilities	24	28
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	(69)	(33)
Net cash used in operating activities from discontinued operations, excluding income taxes	(3)	(4)
Net cash provided by (used in) operating activities	147	(57)
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(208)	(184)
Purchases of businesses or joint venture interests, net of cash acquired	(29)	(11)
Proceeds from sales of facilities and other assets	573	—
Proceeds from sales of marketable securities, long-term investments and other assets	12	6
Purchases of equity investments	(18)	—
Other long-term assets	(10)	2
Net cash provided by (used in) investing activities	320	(187)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(995)	(690)
Proceeds from borrowings under credit facility	995	820
Repayments of other borrowings	(38)	(32)

Proceeds from other borrowings	1	401
Debt issuance costs	—	(4)
Distributions paid to noncontrolling interests	(44)	(11)
Contributions from noncontrolling interests	—	2
Purchase of noncontrolling interests	—	(254)
Proceeds from exercise of stock options	—	7
Other items, net	(14)	(3)
Net cash provided by (used in) financing activities	(95)	236
Net increase (decrease) in cash and cash equivalents	372	(8)
Cash and cash equivalents at beginning of period	356	193
Cash and cash equivalents at end of period	$ 728	$ 185
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (132)	$ (117)
Income tax refunds (payments), net	$ (6)	$ 1

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. At March 31, 2016, we operated 84 hospitals, 20 short-stay surgical hospitals, over 475 outpatient centers, nine facilities in the United Kingdom and six health plans through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI joint venture"). The results of 142 of these facilities, in which we hold noncontrolling interests, are recorded using the equity method of accounting. Our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2015 ("Annual Report"). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). Certain prior-year amounts have been reclassified to conform to the current-year presentation.

Although the Condensed Consolidated Financial Statements and related notes within this document are unaudited, we believe all adjustments considered necessary for a fair presentation have been included and are of a normal recurring nature. In preparing our financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP"), we are required to make estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Operating results for the three month period ended March 31, 2016 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the number of covered lives managed by our health plans and the plans' ability to effectively manage medical costs; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of

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uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

Translation of Foreign Currencies

The accounts of European Surgical Partners, Limited ("Aspen") were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities were translated using the current rate of exchange at the balance sheet date. Results of operations were translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates are accumulated in shareholders' equity.

Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our Compact with Uninsured Patients ("Compact") and other uninsured discount and charity programs.

The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Three Months Ended March 31,	
	2016	2015
General Hospitals:		
Medicare	$ 859	$ 898
Medicaid	373	385
Managed care	2,626	2,405
Indemnity, self-pay and other	437	414

Acute care hospitals — other revenue	7	15
Other:		
Other operations	1,118	670
Net operating revenues before provision for doubtful accounts	$ 5,420	$ 4,787

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $728 million and $356 million at March 31, 2016 and December 31, 2015, respectively. At March 31, 2016 and December 31, 2015, our book overdrafts were approximately $256 million and $301 million, respectively, which were classified as accounts payable.

At March 31, 2016 and December 31, 2015, approximately $175 million and $171 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries and our health plans.

Also at March 31, 2016 and December 31, 2015, we had $110 million and $133 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $63 million and $95 million, respectively, were included in accounts payable.

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During the three months ended March 31, 2016 and 2015, we entered into non-cancellable capital leases of approximately $31 million and $33 million, respectively, primarily for buildings and equipment.

Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets at March 31, 2016 and December 31, 2015:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At March 31, 2016:			
Capitalized software costs	$ 1,495	$ (625)	$ 870
Trade names	106	—	106
Contracts	669	(30)	639
Other	117	(46)	71
Total	$ 2,387	$ (701)	$ 1,686

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2015:			
Capitalized software costs	$ 1,456	$ (594)	$ 862
Trade names	106	—	106
Contracts	653	(26)	627
Other	119	(39)	80
Total	$ 2,334	$ (659)	$ 1,675

Estimated future amortization of intangibles with finite useful lives at March 31, 2016 is as follows:

		Years Ending December 31,					
	Total	2016	2017	2018	2019	2020	Later Years
Amortization of intangible assets	$ 1,207	$ 141	$ 174	$ 146	$ 122	$ 89	$ 535

Investments in Unconsolidated Affiliates

We control 213 of the facilities operated by our Ambulatory Care segment and, therefore, consolidate their results (211 are consolidated within our Ambulatory Care segment and two are consolidated within our Hospital Operations and other segment). We account for many of the facilities our Ambulatory Care segment operates (122 of 335 at March 31, 2016) and four of the hospitals our Hospital Operations and other segment operates under the equity method as investments in unconsolidated affiliates and report only our share of net income attributable to the investee as equity in earnings of unconsolidated affiliates in the accompanying Condensed Consolidated Statements of Operations. Summarized financial information for these equity method investees is included in the following table.

	Three Months Ended March 31, 2016
Net operating revenues	$ 578
Net income	$ 105
Net income attributable to the investees	$ 69

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NOTE 2. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

The principal components of accounts receivable are shown in the table below:

	March 31, 2016	December 31, 2015
Continuing operations:		
Patient accounts receivable	$ 3,606	$ 3,486
Allowance for doubtful accounts	(901)	(887)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	146	144
Net cost reports and settlements payable and valuation allowances	(47)	(42)
	2,804	2,701
Discontinued operations	3	3
Accounts receivable, net	$ 2,807	$ 2,704

At March 31, 2016 and December 31, 2015, our allowance for doubtful accounts was 25.0% and 25.4%, respectively, of our patient accounts receivable. Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. At March 31, 2016 and December 31, 2015, our allowance for doubtful accounts for self-pay was 81.2% and 80.6%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. At March 31, 2016 and December 31, 2015, our allowance for doubtful accounts for managed care was 8.4% and 7.5%, respectively, of our managed care patient accounts receivable.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. The table below shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients and charity care patients, and revenues attributable to Medicaid DSH and other supplemental revenues we recognized in three months ended March 31, 2016 and 2015.

	Three Months Ended March 31,	
	2016	2015
Estimated costs for:		
Self-pay patients	$ 165	$ 164
Charity care patients	$ 44	$ 36
Medicaid DSH and other supplemental revenues	$ 227	$ 247

At March 31, 2016 and December 31, 2015, we had approximately $450 million and $387 million, respectively, of receivables recorded in other current assets and approximately $174 million and $139 million, respectively, of payables recorded in other current liabilities in the accompanying Condensed Consolidated Balance Sheets related to California's provider fee program.

NOTE 3. ASSETS AND LIABILITIES HELD FOR SALE

Our hospitals, physician practices and related assets in Georgia met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. In accordance with the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," we classified $549 million of

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our assets in Georgia as “assets held for sale” in current assets and $101 million of our liabilities in Georgia as “liabilities held for sale” in current liabilities in the accompanying Condensed Consolidated Balance Sheet at December 31, 2015. We completed the sale of our Georgia assets on March 31, 2016 at a transaction price of approximately $575 million and recognized a gain on sale of approximately $113 million. Because we did not sell the related accounts receivable related to the pre-closing period, net receivables of approximately $141 million are included in accounts receivable, less allowance for doubtful accounts in the accompanying Condensed Consolidated Balance Sheet at March 31, 2016.

NOTE 4. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the three months ended March 31, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $28 million primarily related to our Hospital Operations and other segment, consisting of approximately $2 million to write-down other intangible assets, $10 million of employee severance costs, $1 million of restructuring costs, $1 million of contract and lease termination fees, and $14 million in acquisition-related costs, which include $5 million of transaction costs and $9 million of acquisition integration charges.

During the three months ended March 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $29 million, consisting of $6 million of employee severance costs, $3 million of restructuring costs, and $20 million in acquisition-related costs, which include $7 million of transaction costs and $13 million of acquisition integration charges.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our facilities, which are based on programs and initiatives being implemented that are designed to achieve the facility’s most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

At March 31, 2016, our continuing operations consisted of three reportable segments, Hospital Operations and other, Ambulatory Care and Conifer. Within our Hospital Operations and other segment, our regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our reportable business segment level. Our Ambulatory Care segment consists of the operations of our USPI joint venture and our Aspen facilities.

Our Hospital Operations and other segment was structured as follows at March 31, 2016:

- Our Florida region included all of our hospitals and other operations in Florida;

- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;

- Our Southern region included all of our hospitals and other operations in Alabama, Georgia, South Carolina and Tennessee;

- Our Texas region included all of our hospitals and other operations in Missouri, New Mexico and Texas;

- Our Western region included all of our hospitals and other operations in Arizona and California; and

- Our Detroit market included all of our hospitals and other operations in the Detroit, Michigan area.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our statement of operations as they are incurred. Our restructuring plans focus on various aspects of operations, including aligning our operations in the most strategic and cost-effective structure. Certain restructuring and acquisition-related costs are based on estimates. Changes in estimates are recognized as they occur.

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NOTE 5. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt at March 31, 2016 and December 31, 2015:

	March 31, 2016	December 31, 2015
Senior notes:		
5%, due 2019	$ 1,100	$ 1,100
51/2%, due 2019	500	500
63/4%, due 2020	300	300
8%, due 2020	750	750
81/8%, due 2022	2,800	2,800
63/4%, due 2023	1,900	1,900
67/8%, due 2031	430	430
Senior secured notes:		
61/4%, due 2018	1,041	1,041
43/4%, due 2020	500	500
6%, due 2020	1,800	1,800
Floating % due 2020	900	900
41/2%, due 2021	850	850
43/8%, due 2021	1,050	1,050
Capital leases and mortgage notes	853	852
Unamortized issue costs, note discounts and premium	(252)	(263)
Total long-term debt	14,522	14,510
Less current portion	172	127
Long-term debt, net of current portion	$ 14,350	$ 14,383

Credit Agreement

On December 4, 2015, we entered into an amendment to our existing senior secured revolving credit facility (as amended, “Credit Agreement”) in order to, among other things, extend the scheduled maturity date of the facility, reduce the rates of certain interest and fees payable under the facility, and remove certain restrictions with respect to the borrowing base eligibility of certain accounts receivable. The Credit Agreement provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement, which has a scheduled maturity date of December 4, 2020, is collateralized by patient accounts receivable of substantially all of our domestic wholly owned hospitals. In addition, borrowings under the Credit Agreement are guaranteed by substantially all of our wholly owned domestic hospital subsidiaries. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 0.25% to 0.75% per annum or the London Interbank Offered Rate (“LIBOR”) plus a margin ranging from 1.25% to 1.75% per annum, in each case based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans

ranges from 0.25% to 0.375% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At March 31, 2016, we had no cash borrowings outstanding under the Credit Agreement, and we had approximately $4 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $996 million was available for borrowing under the Credit Agreement at March 31, 2016.

Letter of Credit Facility

On March 7, 2014, we entered into a letter of credit facility agreement (“LC Facility”) that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our prior credit agreement, which we transferred to the LC Facility (the “Preexisting Letters of Credit”)), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by and secured by a first priority pledge of the capital stock and other ownership interests of certain of our domestic hospital subsidiaries on an equal ranking basis with our existing senior secured notes.

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Drawings under any letter of credit issued under the LC Facility (including the Preexisting Letters of Credit) that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.875% per annum. An unused commitment fee is payable at an initial rate of 0.50% per annum with a step down to 0.375% per annum based on the secured debt to EBITDA ratio of 3.00 to 1.00. A per annum fee on the aggregate outstanding amount of issued but undrawn letters of credit (including the Preexisting Letters of Credit) will accrue at a rate of 1.875% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At March 31, 2016, we had approximately $139 million of standby letters of credit outstanding under the LC Facility.

NOTE 6. GUARANTEES

At March 31, 2016, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $89 million. We had a total liability of $75 million recorded for these guarantees included in other current liabilities at March 31, 2016.

At March 31, 2016, we also had issued guarantees of the indebtedness and other obligations of our investees to third parties, the maximum potential amount of future payments under which was approximately $35 million. Of the total, $17 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Condensed Consolidated Balance Sheet at March 31, 2016.

NOTE 7. EMPLOYEE BENEFIT PLANS

At March 31, 2016, approximately 1.7 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and time-based restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have longer vesting periods. In addition, we grant performance-based restricted stock units (and, in prior years, have granted performance-based options) that vest subject to the achievement of specified performance goals within a specified timeframe.

Our Condensed Consolidated Statements of Operations for the three months ended March 31, 2016 and 2015 include $14 million and $18 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements recorded in salaries, wages and benefits.

Stock Options

The following table summarizes stock option activity during the three months ended March 31, 2016:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding at December 31, 2015	1,606,842	$ 22.87		
Granted	—	—		
Exercised	(3,950)	4.56		
Forfeited/Expired	(29,392)	4.56		
Outstanding at March 31, 2016	1,573,500	22.75	$ 13	2.9 years
Vested and expected to vest at March 31, 2016	1,573,500	$ 22.75	$ 13	2.9 years
Exercisable at March 31, 2016	1,573,500	$ 22.75	$ 13	2.9 years

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There were 3,950 stock options exercised during the three months ended March 31, 2016 with an aggregate intrinsic value of less than $1 million, and 77,658 stock options exercised during the same period in 2015 with a less than $1 million aggregate intrinsic value.

At March 31, 2016, there were no unrecognized compensation costs related to stock options. Also, there were no stock options granted in the three months ended March 31, 2016 or 2015.

The following table summarizes information about our outstanding stock options at March 31, 2016:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	202,152	2.9 years	$ 4.56	202,152	$ 4.56
$4.57 to $25.089	910,897	3.6 years	20.99	910,897	20.99
$25.09 to $32.569	182,000	0.9 years	26.40	182,000	26.40
$32.57 to $42.529	278,451	1.8 years	39.31	278,451	39.31
	1,573,500	2.9 years	$ 22.75	1,573,500	$ 22.75

Restricted Stock Units

The following table summarizes restricted stock unit activity during the three months ended March 31, 2016:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2015	3,627,232	$ 44.69
Granted	1,231,727	31.08
Vested	(1,223,015)	43.68
Forfeited	(23,639)	45.05
Unvested at March 31, 2016	3,612,305	$ 40.38

In the three months ended March 31, 2016, we granted 474,052 restricted stock units subject to time-vesting, of which 458,379 will vest and be settled ratably over a three-year period from the grant date, and 15,673 will vest and be settled on the third anniversary of the grant date. In January 2016, following the appointment of two new members of our Board of Directors, we also made initial grants totaling 5,084 restricted stock units to these directors, as well as

prorated annual grants totaling 5,614 restricted stock units. Both the initial grants and the annual grants vested immediately, however the initial grants will not settle until the directors' separation from the Board, while the annual grants settle on the third anniversary of the grant date. In addition, we granted 455,437 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of specified three-year performance goals for the years 2016 to 2018. Provided the goals are achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 455,437 units granted, depending on our level of achievement with respect to the performance goals. Moreover, in the three months ended March 31, 2016, we granted 291,540 restricted stock units as a result of our level of achievement with respect to prior-year target performance goals.

At March 31, 2016, there were $117 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.3 years.

NOTE 8. EQUITY

Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the three months ended March 31, 2016 and 2015 (dollars in millions, share amounts in thousands):

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	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock		Additional	Accumulated Other				
	Shares Outstanding	Issued Par Amount	Paid-in Capital	Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balances at December 31, 2015	98,495	$ 7	$ 4,815	$ (164)	$ (1,550)	$ (2,417)	$ 267	$ 958
Net income (loss)	—	—	—	—	(59)	—	13	(46)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(10)	(10)
Contributions from noncontrolling interests	—	—	—	—	—	—	10	10
Other comprehensive income	—	—	—	4	—	—	—	4
Purchases (sales) of businesses and noncontrolling interests	—	—	(7)	—	—	—	21	14
Stock-based compensation expense, tax benefit and issuance of common stock	773	—	(4)	—	—	—	—	(4)
Balances at March 31, 2016	99,268	$ 7	$ 4,804	$ (160)	$ (1,609)	$ (2,417)	$ 301	$ 926
Balances at December 31, 2014	98,382	$ 7	$ 4,614	$ (182)	$ (1,410)	$ (2,378)	$ 134	$ 785
Net income	—	—	—	—	47	—	8	55
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(10)	(10)
Contributions from noncontrolling interests	—	—	—	—	—	—	1	1
Other comprehensive income	—	—	—	3	—	—	—	3
Purchases (sales) of businesses and	—	—	129	—	—	—	—	129

noncontrolling interests								
Stock-based compensation expense and issuance of common stock	782	—	8	—	—	1	—	9
Balance at March 31, 2015	99,164	$ 7	$ 4,751	$ (179)	$ (1,363)	$ (2,377)	$ 133	$ 972

NOTE 9. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Reserves

At March 31, 2016 and December 31, 2015, the aggregate current and long-term professional and general liability reserves in our accompanying Condensed Consolidated Balance Sheets were approximately $784 million and $755 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 1.54% at March 31, 2016 and 2.09% at December 31, 2015.

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period.

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $93 million and $89 million for the three months ended March 31, 2016 and 2015,

respectively.

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NOTE 10. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. Significant judgment is required in both the determination of the probability of a loss and the determination as to whether a loss is reasonably estimable. These determinations are updated at least quarterly and are adjusted to reflect the effects of negotiations, settlements, rulings, advice of legal counsel and technical experts, and other information and events pertaining to a particular matter. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

Governmental Reviews and Lawsuits

Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or “whistleblower” lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. We and our subsidiaries have received inquiries in recent years from government agencies, and we may receive similar inquiries in future periods. The following matters are pending.

- Clinica de la Mama Qui Tam Action and Criminal Investigation—As previously disclosed, we and four of our hospital subsidiaries are defendants in civil qui tam litigation (United States of America, ex rel. Ralph D. Williams v. Health Management Associates, Inc., et al.) that alleges that the contractual arrangements entered into by the hospital subsidiaries with Hispanic Medical Management, Inc. (“HMM”) violated the federal and state anti-kickback statutes and false claims acts. HMM owned and operated clinics that provided, among other things, prenatal care predominantly to uninsured patients. Beginning in 2000, the hospital subsidiaries contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. Subsequently, the Georgia Attorney General’s Office and the U.S. Attorney’s Office intervened in the qui tam action. Effective March 31, 2016, we sold the operating assets of three of the four hospital subsidiaries; however, we retained any potential liabilities arising from the litigation or the U.S. Department of Justice (“DOJ”) investigation discussed below.

If the plaintiff in the pending civil litigation were to prevail, the potential sanctions could include up to three times the reimbursement of relevant government program payments received by the four hospital subsidiaries for uninsured

HMM patients treated at the hospitals, the assessment of civil penalties and potential exclusion from participation in federal healthcare programs.

Also as previously disclosed, the DOJ has been conducting a criminal investigation of us, certain of our subsidiaries and former employees with respect to the contractual arrangements between HMM and the four hospitals. We are cooperating in the investigation and have responded, and continue to respond, to document and other requests pursuant to subpoenas issued to us and the four subsidiaries.

In January 2016, we commenced discussions with the DOJ and the State of Georgia regarding potential resolution of the qui tam action and criminal investigation. In the three months ended March 31, 2016, we increased the aggregate accrual for these matters from $238 million to $407 million to reflect the most recent offer we made on April 25, 2016 to resolve the criminal investigation and civil litigation. The offer was not accepted, but the parties continue to engage in discussions to resolve these matters. There can be no assurance that ongoing discussions will lead to a resolution. The terms of a final resolution of these matters may require us to pay significant fines and penalties and give rise to other costs or adverse consequences that materially exceed the accrual we have established. Based on the ongoing uncertainties and potentially wide range of

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outcomes associated with any potential resolution, we cannot estimate the amount of potential loss or range of reasonably possible loss in excess of the amount accrued that we may face.

In addition to the payment of a monetary penalty, the final terms of any resolution of these matters could include: (i) the execution by the Company of a Corporate Integrity Agreement or a non-prosecution agreement, which may provide for the appointment of a corporate monitor and ongoing compliance audits; (ii) a deferred prosecution agreement by an intermediate subsidiary of the Company; and (iii) a commitment that one or more of the hospital subsidiaries subject to the investigation and proceedings enter into a guilty plea. The non-monetary terms of any resolution could expose us to increased operating costs, reputational harm, administrative burdens, and diminished profits and revenues.

If our efforts to negotiate a settlement ultimately are unsuccessful, and we or our subsidiaries are determined to have violated the federal anti-kickback statute, the sanctions could include fines, which could be significant, and mandatory exclusion from participation in federal healthcare programs.

To the extent that either the civil or criminal matter discussed above is determined adversely to our interests, such determination could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Antitrust Class Action Lawsuit Filed by Registered Nurses in San Antonio

In Maderazo, et al. v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al., filed in June 2006 in the U.S. District Court for the Western District of Texas, a purported class of registered nurses employed by three unaffiliated San Antonio-area hospital systems allege those hospital systems, including Baptist Health System, and other unidentified San Antonio regional hospitals violated Section §1 of the federal Sherman Act by conspiring to depress nurses' compensation and exchanging compensation-related information among themselves in a manner that reduced competition and suppressed the wages paid to such nurses. The suit seeks unspecified damages (subject to trebling under federal law), interest, costs and attorneys' fees. The case had been stayed since 2008; however, in July 2015, the court lifted the stay and re-opened discovery. Because these proceedings are at an early stage, it is impossible at this time to predict their outcome with any certainty; however, we believe that the ultimate resolution of this matter will not have a material effect on our business, financial condition or results of operations. We will continue to seek to defeat class certification and vigorously defend ourselves against the plaintiffs' allegations.

Ordinary Course Matters

We are also subject to other claims and lawsuits arising in the ordinary course of business, including potential claims related to, among other things, the care and treatment provided at our hospitals and outpatient facilities, the application of various federal and state labor laws, tax audits and other matters. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material effect on our business or financial condition.

New claims or inquiries may be initiated against us from time to time. These matters could (1) require us to pay substantial damages or amounts in judgments or settlements, which, individually or in the aggregate, could exceed amounts, if any, that may be recovered under our insurance policies where coverage applies and is available, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) cause us to close or sell hospitals or otherwise modify the way we conduct business.

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The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the three months ended March 31, 2016 and 2015:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Balances at End of Period
Three Months Ended March 31, 2016				
Continuing operations	$ 299	$ 173	$ (45)	$ 427
Discontinued operations	—	—	—	—
	$ 299	$ 173	$ (45)	$ 427
Three Months Ended March 31, 2015				
Continuing operations	$ 73	$ 3	$ (15)	$ 61
Discontinued operations	10	(3)	—	7
	$ 83	$ —	$ (15)	$ 68

For the three months ended March 31, 2016 and 2015, we recorded costs of $173 million and $3 million, respectively, in continuing operations in connection with significant legal proceedings and governmental reviews. During the three months ended March 31, 2015, we reduced a previously established reserve for a legal matter in discontinued operations by approximately $3 million based on updated claims information.

NOTE 11. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the three months ended March 31, 2016 and 2015:

	Three Months Ended March 31,	
	2016	2015
Balances at beginning of period	$ 2,266	$ 401
Net income	80	21
Distributions paid to noncontrolling interests	(34)	(1)

Contributions from noncontrolling interests	6	1
Purchases and sales of businesses and noncontrolling interests, net	63	(214)
Balances at end of period	$ 2,381	$ 208

NOTE 12. INCOME TAXES

During the three months ended March 31, 2016, we recorded income tax expense of $67 million in continuing operations on pre-tax earnings of $105 million. The recorded income tax differs from taxes calculated at the statutory rate primarily due to state income tax expense of approximately $13 million, tax benefits of $21 million related to net income attributable to noncontrolling partnership interests, which is excluded from the computation of the provision for income taxes, tax expense of $29 million related to nondeductible goodwill, tax benefits of $17 million related to nontaxable gains and related changes in deferred taxes, and tax expense of $26 million related to nondeductible litigation.

During the three months ended March 31, 2016, we decreased our estimated liabilities for uncertain tax positions by $3 million, net of related deferred tax assets. The total amount of unrecognized tax benefits at March 31, 2016 was $37 million, of which $34 million, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. Total accrued interest and penalties on unrecognized tax benefits at March 31, 2016 were $5 million, all of which related to continuing operations.

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At March 31, 2016, approximately $6 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

NOTE 13. EARNINGS (LOSS) PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for our continuing operations for three months ended March 31, 2016 and 2015. Net income available (loss attributable) to our common shareholders is expressed in millions and weighted average shares are expressed in thousands.

	Net Income Available (Loss Attributable) to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended March 31, 2016			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (55)	98,768	$ (0.56)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ (55)	98,768	$ (0.56)
Three Months Ended March 31, 2015			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 46	98,699	$ 0.47
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,173	(0.01)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	$ 46	100,872	$ 0.46

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three months ended March 31, 2016 because we did not report income from continuing operations available to common shareholders in that period. In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to common shareholders in the three months ended March 31, 2016, the effect (in thousands) of employee stock options, restricted

stock units and deferred compensation units on the diluted shares calculation would have been an increase of 1,567 shares.

NOTE 14. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are

unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

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Investments	March 31, 2016	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 60	$ 25	$ 35	$ —
	$ 60	$ 25	$ 35	$ —

Investments	December 31, 2015	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 59	$ 24	$ 35	$ —
	$ 59	$ 24	$ 35	$ —

The fair value of our long-term debt (except for borrowings under the Credit Agreement) is based on quoted market prices (Level 1). The inputs used to establish the fair value of the borrowings outstanding under the Credit Agreement are considered to be Level 2 inputs, which include inputs other than quoted prices included in Level 1 that are observable, either directly or indirectly. At March 31, 2016 and December 31, 2015, the estimated fair value of our long-term debt was approximately 99.1% and 96.2%, respectively, of the carrying value of the debt.

NOTE 15. ACQUISITIONS

Preliminary purchase price allocations (representing the fair value of the consideration conveyed) for all acquisitions made during the three months ended March 31, 2016 are as follows:

Current assets	$ 30
Property and equipment	24
Other intangible assets	5
Goodwill	114
Other long-term assets	6
Current liabilities	(9)
Other long-term liabilities	(13)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(62)

Noncontrolling interests	(37)
Cash paid, net of cash acquired	(29)
Gains on consolidations	$ 29

The goodwill generated from these transactions, the majority of which will not be deductible for income tax purposes, was recorded in our Ambulatory Care segment and can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. Approximately $5 million in transaction costs related to prospective and closed acquisitions were expensed during the three months ended March 31, 2016, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statement of Operations.

We are required to allocate the purchase prices of acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, other intangible assets, investments in affiliates and noncontrolling interests for our 2016 and 2015 acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed.

During the three months ended March 31, 2016, we recognized gains totaling $29 million, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

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Pro Forma Information – Unaudited

The following table provides 2016 actual results compared to 2015 pro forma information for Tenet as if the USPI joint venture and Aspen acquisition had occurred at the beginning of the year ended December 31, 2015.

	Three Months Ended March 31,	
	2016	2015
Net operating revenues	$ 5,044	$ 4,629
Equity in earnings of unconsolidated affiliates	$ 24	$ 25
Net income available (loss attributable) to common shareholders	$ (59)	$ 28
Earnings (loss) per share available (attributable) to common shareholders	$ (0.60)	$ 0.28

NOTE 16. SEGMENT INFORMATION

Our business consists of our Hospital Operations and other segment, our Ambulatory Care segment and our Conifer segment. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Our core business is Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, freestanding emergency departments, physician practices and health plans. We also own various related healthcare businesses. At March 31, 2016, our subsidiaries operated 84 hospitals, with a total of 21,529 licensed beds, primarily serving urban and suburban communities in 13 states, and six health plans, as well as hospital-based outpatient centers, freestanding emergency departments and freestanding urgent care centers.

Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our nine Aspen facilities in the United Kingdom. At March 31, 2016, our USPI joint venture had interests in 250 ambulatory surgery centers, 35 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 28 states.

Our Conifer segment provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans. At March 31, 2016, Conifer provided services to more than 800 Tenet and non-Tenet hospitals and other clients nationwide. Our Conifer subsidiary and our Hospital Operations and other segment entered into formal agreements documenting terms and conditions of various services provided by Conifer to Tenet hospitals, as well as certain administrative services provided by our Hospital Operations and other segment to Conifer. The services provided by both parties under these agreements are charged to the other party based on estimated third-party pricing terms.

The following tables include amounts for each of our reportable segments and the reconciling items necessary to agree to amounts reported in the accompanying Condensed Consolidated Balance Sheets and Condensed Consolidated Statements of Operations:

	March 31, 2016	December 31, 2015
Assets:		
Hospital Operations and other	$ 17,131	$ 17,353
Ambulatory Care	5,467	5,159
Conifer	1,168	1,170
Total	$ 23,766	$ 23,682

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	Three Months Ended March 31,	
	2016	2015
Capital expenditures:		
Hospital Operations and other	$ 191	$ 176
Ambulatory Care	12	4
Conifer	5	4
Total	$ 208	$ 184
Net operating revenues:		
Hospital Operations and other	$ 4,397	$ 4,151
Ambulatory Care	429	91
Conifer		
Tenet	167	160
Other customers	218	182
Total Conifer revenues	385	342
Intercompany eliminations	(167)	(160)
Total	$ 5,044	$ 4,424
Adjusted EBITDA:		
Hospital Operations and other	$ 414	$ 418
Ambulatory Care	136	29
Conifer	63	82
Total	$ 613	$ 529
Depreciation and amortization:		
Hospital Operations and other	$ 174	$ 192
Ambulatory Care	25	4
Conifer	13	11
Total	$ 212	$ 207
Adjusted EBITDA	$ 613	$ 529
Depreciation and amortization	(212)	(207)
Impairment and restructuring charges, and acquisition-related costs	(28)	(29)
Litigation and investigation costs	(173)	(3)
Interest expense	(243)	(199)
Gains on sales, consolidation and deconsolidation of facilities	147	—
Investment earnings	1	—
Net income from continuing operations before income taxes	$ 105	$ 91

NOTE 17. RECENT ACCOUNTING STANDARDS

In February 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2016-02, "Leases (Topic 842)" ("ASU 2016-02"), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and previous GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under previous GAAP. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2019.

In March 2016, the FASB issued ASU 2016-09, "Compensation—Stock Compensation (Topic 718) Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-09"), which affects all entities that issue share-based payment awards to their employees. The guidance in ASU 2016-09 simplifies several aspects of the accounting for share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. Some of the areas of simplification apply

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only to nonpublic entities. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2017.

NOTE 18. SUBSEQUENT EVENTS

As previously disclosed, as part of the formation of our USPI joint venture in 2015, we entered into a put/call agreement (the “Put/Call Agreement”) with respect to the equity interests in the joint venture held by our joint venture partners. Each year starting in 2016, our joint venture partners must put to us at least 12.5%, and may put up to 25%, of the equity held by them in the joint venture immediately after the closing. In January 2016, Welsh, Carson, Anderson & Stowe, on behalf of our joint venture partners, delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to the Put/Call Agreement. In April 2016, we paid approximately $127 million to purchase these shares, which increased our ownership interest in the USPI joint venture to approximately 56.3%.

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ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is our Hospital Operations and other segment, which is focused on operating acute care hospitals, ancillary outpatient facilities, freestanding emergency departments, physician practices and health plans. Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI joint venture"), in which we acquired a majority interest on June 16, 2015, and European Surgical Partners Limited ("Aspen") facilities, which we also acquired on June 16, 2015. At March 31, 2016, our USPI joint venture had interests in 250 ambulatory surgery centers, 35 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 28 states, and Aspen operated nine private hospitals and clinics in the United Kingdom. Our Conifer segment provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans, through our Conifer Holdings, Inc. ("Conifer") subsidiary. MD&A, which should be read in conjunction with the accompanying Condensed Consolidated Financial Statements, includes the following sections:

- Management Overview
- Forward-Looking Statements
- Sources of Revenue
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 72 hospitals and six health plans operated throughout the three months ended March 31, 2016 and 2015,

(ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) Saint Louis University Hospital, which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) Central Carolina Hospital and Frye Regional Medical Center, which we divested effective January 1, 2016, and (x)

Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center, and Texas Regional Medical Center at Sunnyvale (collectively, “our North Texas hospitals”), in which we divested a controlling interest effective January 1, 2016, but continue to operate, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to March 31, 2016 and 2015 or to the date of divestiture, as applicable. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. Certain previously reported information, primarily related to our freestanding ambulatory surgery and imaging center assets that were contributed to the USPI joint venture, has been reclassified to conform to the current-year presentation.

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These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

USPI Put Notice—In January 2016, Welsh, Carson, Anderson & Stowe, on behalf of our USPI joint venture partners, delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to a previously disclosed put/call agreement. In April 2016, we paid approximately $127 million to purchase shares subject to the put notice, which increased our ownership interest in the USPI joint venture to approximately 56.3%.

Sale of Georgia Hospitals—On March 31, 2016, we completed the sale of our Atlanta-area hospitals – Atlanta Medical Center and its South Campus, North Fulton Hospital, Spalding Regional Hospital and Sylvan Grove Hospital – as well as 26 physician clinics. As a result of this transaction, we recorded a pre-tax gain on sale of approximately $113 million in the three months ended March 31, 2016.

STRATEGIES AND TRENDS

We are committed to providing the communities we serve with high quality, cost-effective healthcare while growing our business, increasing our profitability and creating long-term value for our shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed below.

Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to healthcare providers through Conifer. With respect to our hospitals, ambulatory care centers and other outpatient businesses, we seek to offer superior quality and

patient services to meet community needs, to make capital and other investments in our facilities and technology, to recruit and retain physicians, and to negotiate competitive contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We are continuing to make significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. In addition, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay and reductions in readmissions for hospitalized patients.

Development Strategies—We remain focused on opportunities to increase our hospital and outpatient revenues, and to expand our Conifer services business, through organic growth, corporate development activities and strategic partnerships.

From time to time, we build new facilities, make acquisitions of healthcare assets and companies, and enter into joint venture arrangements or affiliations with healthcare businesses in markets where we believe our operating strategies can improve performance and create shareholder value. Effective January 1, 2016, we formed two joint ventures with Baylor Scott & White Health (“BSW”) involving the ownership and operation of our North Texas hospitals – which were

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operated by certain of our subsidiaries – and Baylor Medical Center at Garland – which was operated by BSW. The joint ventures will focus on delivering integrated, value-based care primarily to select communities in Rockwall, Collin and Dallas counties. BSW holds a majority ownership interest in the joint ventures.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the three months ended March 31, 2016, we derived approximately 40% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. The surgical facilities in our USPI joint venture specialize in non emergency surgical cases. Due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable in a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. In addition, we have continued growing our imaging and urgent care businesses through our USPI joint venture's acquisitions, including the December 31, 2015 acquisition of CareSpot Express Healthcare, which added 35 urgent care centers in Florida and Tennessee to our USPI joint venture's portfolio of outpatient centers. These acquisitions reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we offer to health system and physician partners to include other outpatient settings beyond the core ambulatory care business, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Furthermore, we continually evaluate joint venture opportunities with other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. Conifer provides services to more than 800 Tenet and non-Tenet hospital and other clients nationwide. Historically, this business has generated high margins and improved our overall results of operations. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals and independent physician associations, clients for these services include health plans, self-insured employers, government agencies and other entities. We also remain focused on developing, acquiring or entering into joint venture arrangements to establish new capabilities at Conifer.

General Economic Conditions—We believe that slow wage growth in some of the markets our hospitals serve and other adverse economic conditions have had a negative impact on our bad debt expense levels and payer mix. However, as the economy continues to recover, we expect to experience improvements in these metrics relative to recent levels. We believe our volumes were positively impacted in the three months ended March 31, 2016 by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. We believe our patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher

patient co-pays and deductibles, and demographic trends. In addition, in several markets, we have formed clinically integrated organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of the Affordable Care Act—We anticipate that we will continue to benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (“Affordable Care Act” or “ACA”) that have extended insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by governmental payers, we began to receive reimbursement for caring for previously uninsured and underinsured patients in 2014. Through collaborative efforts with local community organizations, we launched a campaign under the banner “Path to Health” to assist our hospitals in educating and enrolling uninsured patients in insurance plans. At

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March 31, 2016, we operated hospitals in six of the states (Arizona, California, Illinois, Massachusetts, Michigan and Pennsylvania) that have expanded their Medicaid programs.

Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is important that we make steady and measurable progress in successfully integrating acquired businesses and new joint ventures into our business processes, as appropriate. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

RESULTS OF OPERATIONS—OVERVIEW

The following tables show operating statistics for our continuing operations, which includes the results of (i) our same 72 hospitals and six health plans operated throughout the three months ended March 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) Saint Louis University Hospital, which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) Central Carolina Hospital and Frye Regional Medical Center, which we divested effective January 1, 2016, and (x) our North Texas hospitals, in which we divested a controlling interest effective January 1, 2016, but continue to operate, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to March 31, 2016 and 2015 or to the date of divestiture, as applicable. We believe this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses.

	Continuing Operations Three Months Ended March 31,		Increase (Decrease)	
Selected Operating Statistics	2016	2015		
Hospital Operations and other				
Number of hospitals (at end of period)	80	80	—	(1)
Total admissions	211,799	208,333	1.7	%
Adjusted patient admissions(2)	362,819	349,097	3.9	%
Paying admissions (excludes charity and uninsured)	201,436	197,383	2.1	%
Charity and uninsured admissions	10,363	10,950	(5.4)	%
Emergency department visits	925,972	875,077	5.8	%
Total surgeries	132,584	121,403	9.2	%
Patient days — total	1,010,514	975,912	3.5	%
Adjusted patient days(2)	1,714,369	1,618,516	5.9	%
Average length of stay (days)	4.77	4.68	1.9	%

Average licensed beds	21,524		20,823		3.4	%
Utilization of licensed beds(3)	51.6	%	52.1	%	(0.5)	%(1)
Total visits	2,146,618		1,994,573		7.6	%
Paying visits (excludes charity and uninsured)	1,984,515		1,837,376		8.0	%
Charity and uninsured visits	162,103		157,197		3.1	%
Ambulatory Care						
Total consolidated facilities (at end of period)	211		64		147	(1)
Total cases	444,239		150,771		194.6	%

(1) The change is the difference between the 2016 and 2015 amounts shown.

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Total admissions increased by 3,466, or 1.7%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. Total surgeries increased by 9.2% in the three months ended March 31, 2016 compared

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to the same period in 2015. Our emergency department visits increased 5.8% in the three months ended March 31, 2016 compared to the same period in the prior year. Our volumes were positively impacted by acquisitions, as well as, we believe, incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy.

	Continuing Operations Three Months Ended March 31,		Increase
Revenues	2016	2015	(Decrease)
Net operating revenues before provision for doubtful accounts	$ 5,420	$ 4,787	13.2 %
Hospital Operations and other			
Revenues from charity and the uninsured	$ 223	$ 264	(15.5) %
Net inpatient revenues(1)	$ 2,781	$ 2,691	3.3 %
Net outpatient revenues(1)	$ 1,514	$ 1,412	7.2 %
Ambulatory Care revenues	$ 429	$ 91	371.4 %
Conifer revenues	$ 385	$ 342	12.6 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $78 million and $106 million for the three months ended March 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $145 million and $158 million for the three months ended March 31, 2016 and 2015, respectively.

Net operating revenues before provision for doubtful accounts increased by $633 million, or 13.2%, in the three months ended March 31, 2016 compared to the same period in 2015, primarily due to acquisitions, increases in our outpatient volumes and improved managed care pricing. Net operating revenues before provision for doubtful accounts in the three months ended March 31, 2016 included $57 million of net revenues from the California provider fee program described in our Annual Report compared to $46 million during the three months ended March 31, 2015.

	Continuing Operations Three Months Ended March 31,		Increase
Provision for Doubtful Accounts	2016	2015	(Decrease)
Provision for doubtful accounts	$ 376	$ 363	3.6 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	6.9 %	7.6 %	(0.7)%(1)

(1) The change is the difference between the 2016 and 2015 amounts shown.

Provision for doubtful accounts increased by $13 million, or 3.6%, in the three months ended March 31, 2016 compared to the same period in 2015, and provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 6.9% and 7.6% for the three months ended March 31, 2016 and 2015, respectively. The decrease in the provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts primarily related to the impact of the $41 million decrease in revenues from charity and the uninsured. Our accounts receivable days outstanding ("AR Days") from continuing operations were 50.6 days at March 31, 2016 and 49.5 days at December 31, 2015, within our target of less than 55 days.

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Selected Operating Expenses	Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 2,017	$ 1,908	5.7 %
Supplies	725	670	8.2 %
Other operating expenses	1,073	1,005	6.8 %
Total	$ 3,815	$ 3,583	6.5 %
Ambulatory Care			
Salaries, wages and benefits	$ 146	$ 24	508.3 %
Supplies	86	17	405.9 %
Other operating expenses	86	21	309.5 %
Total	$ 318	$ 62	412.9 %
Conifer			
Salaries, wages and benefits	$ 239	$ 193	23.8 %
Other operating expenses	83	67	23.9 %
Total	$ 322	$ 260	23.8 %
Total			
Salaries, wages and benefits	$ 2,402	$ 2,125	13.0 %
Supplies	811	687	18.0 %
Other operating expenses	1,242	1,093	13.6 %
Total	$ 4,455	$ 3,905	14.1 %
Rent/lease expense(1)			
Hospital Operations and other	$ 61	$ 54	13.0 %
Ambulatory Care	17	7	142.9 %
Conifer	4	3	33.3 %
Total	$ 82	$ 64	28.1 %

(1) Included in other operating expenses.

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits per adjusted patient admission(1)	$ 5,559	$ 5,466	1.7 %
Supplies per adjusted patient admission(1)	1,998	1,919	4.1 %
Other operating expenses per adjusted patient admission(1)	2,980	2,899	2.8 %
Total per adjusted patient admission	$ 10,537	$ 10,284	2.5 %

(1) Adjusted patient admissions represents actual patient admissions adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Salaries, wages and benefits per adjusted patient admission increased 1.7% in the three months ended March 31, 2016 compared to the same period in 2015. This change is primarily due to annual merit increases for certain of our employees and increased employee health benefits costs in the three months ended March 31, 2016 compared to the three months ended March 31, 2015.

Supplies expense per adjusted patient admission increased 4.1% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. The change in supplies expense was primarily attributable to higher costs for pharmaceuticals and cardiology supplies, and volume growth in our higher acuity supply-intensive surgical services.

Other operating expenses per adjusted patient admission increased by 2.8% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. This increase is due to higher contracted services

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and medical fees, as well as increased costs associated with our health plans due to an increase in covered lives, which costs were offset by increased health plan revenues. Malpractice expense was $2 million higher in the 2016 period compared to the 2015 period. The 2016 period included an unfavorable adjustment of approximately $12 million due to a 55 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of approximately $5 million as a result of a 26 basis point decrease in the interest rate in the 2015 period.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $728 million at March 31, 2016 compared to $356 million at December 31, 2015.

Significant cash flow items in the three months ended March 31, 2016 included:

- Proceeds from sales of facilities and other assets of $573 million;
- Capital expenditures of $208 million;
- Purchases of businesses for $29 million;
- $117 million in aggregate annual 401(k) contributions and $150 million in annual incentive compensation payments, which were accrued as compensation expense in 2015; and
- Interest payments of $132 million.

Net cash provided by operating activities was $147 million in the three months ended March 31, 2016 compared to $57 million net cash used in operating activities in the three months ended March 31, 2015. Key positive and negative factors contributing to the change between the 2016 and 2015 periods include the following:

- Increased income from continuing operations before income taxes of $84 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the three months ended March 31, 2016 compared to the three months ended March 31, 2015;

- $44 million less cash used by the change in accounts receivable, net of provision for doubtful accounts, in the 2016 period;

- Approximately $132 million of additional net cash proceeds in the 2016 period related to supplemental Medicaid programs, primarily in California and Texas;

- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $18 million and $9 million, respectively, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015;

- An increase of $36 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and

- Higher interest payments of $15 million.

Cash flows from operating activities in the first quarter of the calendar year are usually lower than in subsequent quarters of the year, primarily due to the timing of certain working capital requirements during the first quarter, including our annual 401(k) matching contributions and annual incentive compensation payments.

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FORWARD-LOOKING STATEMENTS

The information in this report includes “forward-looking statements” within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. These forward-looking statements represent management’s current expectations, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors — many of which we are unable to predict or control — that may cause our actual results, performance or achievements, or healthcare industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the risks described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in our Annual Report and in this report. Should one or more of the risks and uncertainties described in our Annual Report or this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statement. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

All forward-looking statements attributable to us are expressly qualified in their entirety by this cautionary statement.

SOURCES OF REVENUE

We earn revenues for patient services from a variety of sources, primarily managed care payers and the federal Medicare program, as well as state Medicaid programs, indemnity-based health insurance companies and self-pay patients (that is, patients who do not have health insurance and are not covered by some other form of third-party arrangement).

The table below shows the sources of net patient revenues before provision for doubtful accounts for our Hospital Operations and other segment, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Three Months Ended March 31,		
Net Patient Revenues from:	2016	2015	Increase (Decrease)(1)
Medicare	20.0%	21.9%	(1.9) %
Medicaid	8.7 %	9.4 %	(0.7) %
Managed care	61.1%	58.6%	2.5 %
Indemnity, self-pay and other	10.2%	10.1%	0.1 %

(1) The increase (decrease) is the difference between the 2016 and 2015 percentages shown.

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Our payer mix on an admissions basis for our Hospital Operations and other segment, expressed as a percentage of total admissions from all sources, is shown below:

	Three Months Ended March 31,		
Admissions from:	2016	2015	Increase (Decrease)(1)
Medicare	27.2%	28.0%	(0.8) %
Medicaid	7.3 %	8.2 %	(0.9) %
Managed care	58.1%	56.3%	1.8 %
Indemnity, self-pay and other	7.4 %	7.5 %	(0.1) %

(1) The increase (decrease) is the difference between the 2016 and 2015 percentages shown.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services (“CMS”) is the single largest payer of healthcare services in the United States. Approximately 129 million Americans rely on healthcare benefits through Medicare, Medicaid and the Children’s Health Insurance Program (“CHIP”). These three programs are authorized by federal law and directed by CMS, an agency of the U.S. Department of Health and Human Services (“HHS”). Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation’s main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes “Part A” and “Part B”), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called “Part C” or “MA Plans”), includes health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues from continuing operations of our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the three months ended March 31, 2016 and 2015 are set forth in the following table:

Three Months Ended

Revenue Descriptions	March 31, 2016	2015
Medicare severity-adjusted diagnosis-related group — operating	$ 474	$ 457
Medicare severity-adjusted diagnosis-related group — capital	43	42
Outliers	22	18
Outpatient	222	234
Disproportionate share	78	88
Direct Graduate and Indirect Medical Education(1)	64	67
Other(2)	(17)	11
Adjustments for prior-year cost reports and related valuation allowances	13	22
Total Medicare net patient revenues	$ 899	$ 939

(1) Includes Indirect Medical Education revenues earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.

(2) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

A general description of the types of payments we receive for services provided to patients enrolled in the Original Medicare Plan is provided in our Annual Report. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found under "Regulatory and Legislative Changes" below.

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Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 19.0% and 19.1% of total net patient revenues before provision for doubtful accounts of our continuing general hospitals for the three months ended March 31, 2016 and 2015, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the three months ended March 31, 2016 and 2015, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately $227 million and $247 million, respectively.

Several states in which we operate face budgetary challenges that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state’s budget, states can be expected to adopt or consider adopting future legislation designed to reduce or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted provider fee programs or received waivers under Section 1115 of the Social Security Act. Under a Medicaid waiver, the federal government waives certain Medicaid requirements, thereby giving states flexibility in the operation of their Medicaid program to allow states to test new approaches and demonstration projects to improve care. Generally the Section 1115 waivers are for a period of five years with an option to extend the waiver for three additional years. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

Because we cannot predict what actions the federal government or the states may take under existing legislation and future legislation to address budget gaps, deficits, Medicaid expansion, provider fee programs or Medicaid section 1115 waivers, we are unable to assess the effect that any such legislation might have on our business, but the impact on our future financial position, results of operations or cash flows could be material.

Medicaid-related patient revenues from continuing operations recognized by our Hospital Operations and other segment from Medicaid-related programs in the states in which our hospitals are located, as well as from Medicaid programs in neighboring states, for the three months ended March 31, 2016 and 2015 are set forth in the table below:

	Three Months Ended March 31,			
	2016		2015	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
California	$ 104	$ 103	$ 80	$ 94

Michigan	98	73	85	77
Texas	52	61	94	59
Alabama	27	—	3	—
Florida	22	42	24	41
Georgia	19	9	17	9
Pennsylvania	19	51	17	48
Illinois	18	18	28	10
Massachusetts	8	14	9	12
Arizona	4	55	(2)	26
South Carolina	2	9	4	9
Tennessee	1	8	2	8
North Carolina	—	—	6	1
Missouri	(1)	—	18	4
	$ 373	$ 443	$ 385	$ 398

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Regulatory and Legislative Changes

Material updates to the information set forth in our Annual Report about the Medicare and Medicaid payment systems are provided below.

Proposed Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year. On April 18, 2016, CMS issued Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2017 Rates ("Proposed IPPS Rule"). The Proposed IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.8% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record ("EHR") technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS is also proposing certain adjustments to the estimated 2.8% market basket increase and the outlier baseline that result in a net operating payment update of 0.65% (before budget neutrality adjustments), including:

- Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.5%, respectively;

- A documentation and coding recoupment reduction of 1.5% as required by the American Taxpayer Relief Act of 2012;

- Prospective reversal of the 0.2% reduction related to the two-midnights rule that was first imposed in federal fiscal year ("FFY") 2014;

- A one-time increase of 0.6% to reverse the 0.2% two-midnights rule reductions imposed in FFYs 2014 through 2016; and

- A 0.2% reduction in the FFY 2016 estimated outlier baseline of 5.3% to ensure that FFY 2017 outlier payments do not exceed 5.1% of total IPPS payments.

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Updates to the factors used to determine the amount and distribution of Medicare uncompensated care disproportionate share ("UC-DSH") payments;

- A 1.73% net increase in the capital federal MS-DRG rate;

- An increase in the cost outlier threshold from $22,544 to $23,681; and

- A proposed three-year transition beginning in FFY 2018 to use uncompensated care to determine the distribution of the UC-DSH payments.

CMS projects that the combined impact of the payment and policy changes in the Proposed IPPS Rule will yield an average 0.6% increase in operating MS-DRG payments for hospitals in large urban areas (populations over one million) in FFY 2016. The proposed payment and policy changes affecting operating MS-DRG payments and other proposals, notably those affecting Medicare UC-DSH payments, would result in an estimated 0.1% increase in our annual IPPS payments, which yields an estimated decrease of approximately $2 million in our annual Medicare IPPS payments. Because of the uncertainty regarding factors that may influence our future IPPS payments by individual hospital, including legislative action, admission volumes, length of stay and case mix, as well as potential changes to the proposed rule, we cannot provide any assurances regarding our estimate of the impact of the proposed changes.

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PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service healthcare delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned “primary care” physician. The member’s care is then managed by his or her primary care physician and other network providers in accordance with the HMO’s quality assurance and utilization review guidelines so that appropriate healthcare can be efficiently delivered in the most cost-effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted healthcare providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted healthcare providers. PPO members who use contracted healthcare providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible healthcare plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient revenues during the three months ended March 31, 2016 and 2015 was $2.6 billion and $2.4 billion, respectively. Approximately 62% of our managed care net patient revenues for the three months ended March 31, 2016 was derived from our top ten managed care payers. National payers generated approximately 44% of our total net managed care revenues. The remainder comes from regional or local payers. At both March 31, 2016 and December 31, 2015, approximately 59% of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient’s bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at March 31, 2016, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders

subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefitted from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate recently, and we believe the moderation could continue in future years. In the three months

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ended March 31, 2016, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

An indemnity-based agreement generally requires the insurer to reimburse an insured patient for healthcare expenses after those expenses have been incurred by the patient, subject to policy conditions and exclusions. Unlike an HMO member, a patient with indemnity insurance is free to control his or her utilization of healthcare and selection of healthcare providers.

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