TENET HEALTHCARE CORP
Form 10-K
February 25, 2019
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-K

x **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2018**
OR

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

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

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

1445 Ross Avenue, Suite 1400

Dallas, TX 75202
(Address of principal executive offices, including zip code)

(469) 893-2200
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common stock, $0.05 par value	New York Stock Exchange
6.875% Senior Notes due 2031	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

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Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No ¨

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ¨ No x

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

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

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

Large accelerated filer x	Accelerated filer ¨	Non-accelerated filer ¨
Smaller reporting company ¨	Emerging growth company ¨	

If an emerging growth company, indicate by check mark if the Registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

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

As of June 30, 2018, the aggregate market value of the shares of common stock held by non-affiliates of the Registrant (treating directors, executive officers who were SEC reporting persons, and holders of 10% or more of the common stock outstanding as of that date, for this purpose, as affiliates) was approximately $2.3 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on Friday, June 29, 2018. As of January 31, 2019, there were 102,667,337 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE
Portions of the Registrant's definitive proxy statement for the 2019 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

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PART I.
ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a national, diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks, primarily in large urban and suburban markets. Through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI"), at December 31, 2018, we operated 68 hospitals (three of which we have since divested), 23 surgical hospitals and approximately 475 outpatient centers throughout the United States. In addition, our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other, Ambulatory Care and Conifer. Additional information about our business segments is provided below; statistical data for the segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

The healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA"). It is difficult to predict the full impact of regulatory uncertainty on our future revenues and operations. In addition, we believe that several key trends are shaping the demand for healthcare services: (1) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (2) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (3) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (4) consolidation continues across the entire healthcare sector. Our ability to execute on our strategies and respond to these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. For information about our strategies, see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

We are focused on improving operational effectiveness, increasing capital efficiency and margins, expanding patient access points, enhancing the customer care experience in every part of our operations, and growing our higher-acuity inpatient service lines, as well as aligning service line growth with community demand. We believe our inpatient admissions have been constrained in recent years by increased competition, utilization pressure by managed care organizations, new delivery models that are designed to lower the utilization of acute care hospital services, the effects of higher patient co-pays, co-insurance amounts and deductibles, changing consumer behavior, and adverse economic conditions and demographic trends in certain of our markets. However, we also believe that emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our ambulatory care business, cultivation of our culture of service, participation in Medicare Advantage health plans that are experiencing higher growth rates than traditional Medicare plans, and contracting strategies that create shared value with payers should help us grow our patient volumes over time.

We continue to exit service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. To that end, in 2018 we divested eight hospitals in the United States, as well as all of our operations in the United Kingdom. In addition, in January 2019, we completed the previously announced sale of three hospitals

in the Chicago area that we owned at December 31, 2018. We intend to continue to further refine our portfolio of hospitals and other healthcare facilities when we believe such refinements will help us improve profitability, allocate capital more effectively in areas where we have a stronger presence, deploy proceeds on higher-return investments across our business, enhance cash generation and lower our ratio of debt-to-Adjusted EBITDA.

We also remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We opened eight new outpatient centers in the year ended December 31, 2018, and we acquired 10 outpatient businesses, including two surgical hospitals. We believe USPI's surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability, flexibility and convenience. Moreover, due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable at a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to increase. We have also continued to grow our imaging and urgent care businesses through USPI to reflect our broader strategies to (1) offer more services to patients, (2) broaden the

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capabilities we offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

In addition to providing revenue cycle management services to healthcare systems and physicians, Conifer provides support to both providers and self-insured employers seeking assistance with clinical integration, financial risk management and population health management. At December 31, 2018, Conifer served approximately 750 Tenet and non-Tenet hospital and other clients nationwide. As previously announced, we are exploring strategic alternatives for Conifer. There can be no assurance that this process will result in a consummated transaction.

We have also undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions (including streamlining corporate overhead and centralized support functions), the renegotiation of contracts with suppliers and vendors, and the consolidation of office locations. In 2019, we are continuing to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing certain functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—At December 31, 2018, our subsidiaries operated 68 hospitals, including one children's hospital, two specialty hospitals and one critical access hospital, serving primarily urban and suburban communities in 10 states. (Following the sale of our Chicago-area hospitals and related operations effective January 28, 2019, our subsidiaries operated 65 hospitals in nine states.) Our subsidiaries had sole ownership of 57 of the hospitals we operated at December 31, 2018, nine were owned or leased by entities that are, in turn, jointly owned by a Tenet subsidiary and a healthcare system partner, and two were owned by third parties and leased by our wholly owned subsidiaries. Our Hospital Operations and other segment also included 165 outpatient centers at December 31, 2018, the majority of which are freestanding urgent care centers, provider-based diagnostic imaging centers, off-campus emergency departments and provider-based ambulatory surgery centers. In addition, at December 31, 2018, our subsidiaries owned or leased and operated: a number of medical office buildings, all of which were located on, or nearby, our hospital campuses; over 740 physician practices; accountable care organizations and clinically integrated networks; and other ancillary healthcare businesses.

Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: (1) changes in federal and state healthcare regulations; (2) the business environment, economic conditions and demographics of local communities in which we operate; (3) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (4) seasonal cycles of illness; (5) climate and weather conditions; (6) physician recruitment, retention and attrition; (7) advances in technology and treatments that reduce length of stay; (8) local healthcare competitors; (9) managed care contract negotiations or terminations; (10) the number of patients with high-deductible health insurance plans; (11) hospital performance data on quality measures and patient satisfaction, as well as standard charges for our services; (12) any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and (13) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most have intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals provide tertiary care services, such as cardiothoracic surgery, neonatal intensive care and neurosurgery, and some also offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Our children's hospital provides

tertiary and quaternary pediatric services, including organ and bone marrow transplants, as well as burn services. Moreover, a number of our hospitals offer advanced treatment options for patients, including limb-salvaging vascular procedures, acute level 1 trauma services, comprehensive intravascular stroke care, minimally invasive cardiac valve replacement, cutting edge imaging technology, and telemedicine access for selected medical specialties.

Each of our hospitals (other than our critical access hospital) is accredited by The Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. Although our critical access hospital has not sought to be accredited, it also participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation.

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The table below lists, by state, the hospitals wholly owned, operated as part of a joint venture, or leased and operated by our wholly owned subsidiaries at December 31, 2018:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Baptist Medical Center[1]	Homewood	595	JV/Owned
Citizens Baptist Medical Center[1][2]	Talladega	122	JV/Leased
Princeton Baptist Medical Center[1][2]	Birmingham	505	JV/Leased
Shelby Baptist Medical Center[1][2]	Alabaster	252	JV/Leased
Walker Baptist Medical Center[1][2]	Jasper	267	JV/Leased
Arizona			
Abrazo Arizona Heart Hospital[3]	Phoenix	59	Owned
Abrazo Arrowhead Campus	Glendale	217	Owned
Abrazo Central Campus	Phoenix	221	Owned
Abrazo Scottsdale Campus	Phoenix	136	Owned
Abrazo West Campus	Goodyear	188	Owned
Holy Cross Hospital[4][5]	Nogales	25	JV/Owned
St. Joseph’s Hospital[4]	Tucson	486	JV/Owned
St. Mary’s Hospital[4]	Tucson	400	JV/Owned
California			
Desert Regional Medical Center[6]	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital and Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center[7]	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	163	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center[8]	San Ramon	123	JV/Owned
Sierra Vista Regional Medical Center	San Luis Obispo	162	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	536	Owned
Florida Medical Center – a campus of North Shore	Lauderdale Lakes	459	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	337	Owned
Palm Beach Gardens Medical Center	Palm Beach Gardens	199	Owned
Palmetto General Hospital	Hialeah	368	Owned
St. Mary’s Medical Center	West Palm Beach	460	Owned
West Boca Medical Center	Boca Raton	195	Owned
Illinois			
Louis A. Weiss Memorial Hospital[9]	Chicago	236	Owned

Westlake Hospital[9]	Melrose Park	230	Owned
West Suburban Medical Center[9]	Oak Park	234	Owned

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Hospital	Location	Licensed Beds	Status
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	147	Owned
MetroWest Medical Center – Leonard Morse Campus	Natick	160	Owned
Saint Vincent Hospital	Worcester	283	Owned
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	273	Owned
Harper University Hospital	Detroit	470	Owned
Huron Valley-Sinai Hospital	Commerce Township	158	Owned
Hutzel Women's Hospital	Detroit	114	Owned
Rehabilitation Institute of Michigan(3)	Detroit	69	Owned
Sinai-Grace Hospital	Detroit	404	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	479	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
The Hospitals of Providence East Campus	El Paso	182	Owned
The Hospitals of Providence Memorial Campus	El Paso	480	Owned
The Hospitals of Providence Sierra Campus	El Paso	297	Owned
The Hospitals of Providence Transmountain Campus	El Paso	106	Owned
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	161	Owned
North Central Baptist Hospital	San Antonio	429	Owned
Northeast Baptist Hospital	San Antonio	371	Owned
Resolute Health Hospital	New Braunfels	128	Owned
St. Luke's Baptist Hospital	San Antonio	287	Owned
Valley Baptist Medical Center	Harlingen	586	Owned
Valley Baptist Medical Center – Brownsville	Brownsville	243	Owned
Total Licensed Beds		**17,937**	

(1) Operated by a limited liability company formed as part of a joint venture with Baptist Health System, Inc. ("BHS"), a not-for-profit healthcare system in Alabama; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2018, and BHS owned a 40% interest.

(2) In order to receive certain tax benefits for these hospitals, which were operated as nonprofit hospitals prior to our joint venture with BHS, we have entered into arrangements with the City of Talladega, the City of Birmingham, the City of Alabaster and the City of Jasper such that a Medical Clinic Board owns each of these hospitals, and the hospitals are leased to our joint venture entity. These capital leases expire between November 2025 and September 2036, but contain two optional renewal terms of 10 years each.

(3) Specialty hospital.

(4) Owned by a limited liability company formed as part of a joint venture with Dignity Health and Ascension Arizona, each of which is a not-for-profit healthcare system; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2018, Dignity Health owned a 22.5% interest and Ascension Arizona owned a

17.5% interest.

(5) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital.

(6) Lease expires in May 2027.

(7) Lease expires in July 2045.

(8) Owned by a limited liability company formed as part of a joint venture with John Muir Health ("JMH"), a not-for-profit healthcare system in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the entity at December 31, 2018, and JMH owned a 49% interest.

(9) We sold our Chicago-area hospitals and related operations effective January 28, 2019.

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Information regarding the utilization of licensed beds and other operating statistics at December 31, 2018, 2017 and 2016 can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

At December 31, 2018, our Hospital Operations and other segment also included 50 diagnostic imaging centers, 12 off-campus emergency departments, 11 ambulatory surgery centers and one urgent care center operated as departments of our hospitals and under the same license, as well as 91 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of six diagnostic imaging centers, eight emergency facilities (seven of which are licensed as microhospitals), two ambulatory surgery centers and 75 urgent care centers. Nearly all of our freestanding urgent care centers are managed by USPI and operated under our national MedPost brand. Over half of the outpatient centers in our Hospital Operations and other segment at December 31, 2018 were in California, Florida and Texas, the same states where we had the largest concentrations of licensed hospital beds. Strong concentrations of hospital beds and outpatient centers within market areas may help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Accountable Care Organizations and Clinically Integrated Networks—We own, control or operate five accountable care organizations ("ACOs") and 10 clinically integrated networks ("CINs") – in Alabama, Arizona, California, Florida, Massachusetts, Michigan, Missouri, Tennessee and Texas – and participate in four additional ACOs and CINs with other healthcare providers for select markets in Arizona and Texas. An ACO is a group of providers and suppliers that work together to redesign delivery processes in an effort to achieve high-quality and efficient provision of services under contract with CMS. ACOs that achieve quality performance standards established by the U.S. Department of Health and Human Services ("HHS") are eligible to share in a portion of the amounts saved by the Medicare program. A CIN coordinates the healthcare needs of the communities served by its network of providers with the purpose of improving the quality and efficiency of healthcare services through collaborative programs, including contracts with managed care payers that create a high degree of interdependence and cooperation among the network providers. Because they promote accountability and coordination of care, ACOs and CINs are intended to produce savings as a result of improved quality and operational efficiencies. Both ACOs and CINs operate using a range of payment and care coordination models.

Health Plans—We previously announced our intention to sell or otherwise dispose of our health plan businesses because they are not a core part of our long-term growth strategy. To that end, we sold, divested the membership of or discontinued four health plans in 2017 and, in 2018, we divested our Chicago-based preferred provider network and our Southern California Medicare Advantage plan. Health plans we have not sold outright are being wound-down; however, during this time, they continue to be subject to numerous federal and state statutes and regulations related to their business operations, and each such health plan continues to be licensed by one or more agencies in the states in which they conduct business. In addition, insurance regulations in the states in which we currently operate have required us to maintain cash reserves in connection with certain health plans throughout the wind-down process.

AMBULATORY CARE SEGMENT

Our Ambulatory Care segment is comprised of the operations of USPI and included nine facilities in the United Kingdom until their divestiture in August 2018. At December 31, 2018, USPI had interests in 255 ambulatory surgery centers, 36 urgent care centers operated under the CareSpot brand, 23 imaging centers and 23 surgical hospitals in 27 states. Of these 337 facilities, 208 are jointly owned with healthcare systems. At December 31, 2018, we owned approximately 95% of USPI, and Baylor University Medical Center ("Baylor") owned approximately 5%.

Operations of USPI—USPI acquires and develops its facilities primarily through the formation of joint ventures with physicians and healthcare systems. USPI's subsidiaries hold ownership interests in the facilities directly or indirectly and operate the facilities on a day-to-day basis through management services contracts. We believe that this acquisition and development strategy and operating model will enable USPI to continue to grow because of various industry trends we have seen emerge in recent years, namely that: (1) consumers are increasingly selecting services and providers based on cost and convenience, as well as quality; (2) more procedures are shifting from inpatient to outpatient settings; and (3) healthcare providers are entering into joint ventures to maximize effectiveness, reduce costs and build clinically integrated networks.

USPI's surgical facilities primarily specialize in non-emergency cases. We believe surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability and convenience. Medical emergencies at acute care hospitals often demand the unplanned use of operating rooms and result in the postponement or delay of scheduled surgeries, disrupting physicians' practices and inconveniencing patients. Outpatient facilities generally

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provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases. In addition, many physicians choose to perform surgery in outpatient facilities because their patients prefer the comfort of a less institutional atmosphere and the convenience of simplified admissions and discharge procedures.

New surgical techniques and technology, as well as advances in anesthesia, have significantly expanded the types of surgical procedures that are being performed in surgery centers and have helped drive the growth in outpatient surgery. Improved anesthesia has shortened recovery time by minimizing post-operative side effects, such as nausea and drowsiness, thereby avoiding the need for overnight hospitalization in many cases. Furthermore, some states permit surgery centers to keep a patient for up to 23 hours, which allows for more complex surgeries, previously performed only in an inpatient setting, to be performed in a surgery center.

In addition to these technological and other clinical advancements, a changing payer environment has contributed to the growth of outpatient surgery relative to all surgery performed. Government programs, private insurance companies, managed care organizations and self-insured employers have implemented cost-containment measures to limit increases in healthcare expenditures, including procedure reimbursement. Furthermore, as self-funded employers are looking to curb annual increases in their employee health benefits costs, they continue to shift additional financial responsibility to patients through higher co-pays, deductibles and premium contributions. These cost-containment measures have contributed to the shift in the delivery of healthcare services away from traditional inpatient hospitals to more cost-effective alternate sites, including surgical facilities. We believe that surgeries performed at surgical facilities are generally less expensive than hospital-based outpatient surgeries because of lower facility development costs, more efficient staffing and space utilization, and a specialized operating environment focused on quality of care and cost containment.

We operate USPI's facilities, structure our joint ventures, and adopt staffing, scheduling, and clinical systems and protocols with the goal of increasing physician productivity. We believe that this focus on physician satisfaction, combined with providing high-quality healthcare in a friendly and convenient environment for patients, will continue to increase the number of procedures performed at our facilities each year. Our joint ventures also enable healthcare systems to offer patients, physicians and payers the cost advantages, convenience and other benefits of ambulatory care in a freestanding facility and, in certain markets, establish networks needed to manage the full continuum of care for a defined population. Further, these relationships allow the healthcare systems to focus their attention and resources on their core business without the challenge of acquiring, developing and operating these facilities.

CONIFER SEGMENT

Nearly all of the services comprising the operations of our Conifer segment are provided by Conifer Health Solutions, LLC or one of its direct or indirect wholly owned subsidiaries. At December 31, 2018, we owned 76.2% of Conifer Health Solutions, LLC, and Catholic Health Initiatives ("CHI") had a 23.8% ownership position. We have been exploring strategic alternatives for Conifer, including a potential sale or merger, a tax-efficient spin-off or a combination of alternative transactions. There can be no assurance that this process will result in a consummated transaction, and we may ultimately decide to retain all or part of Conifer's business.

Services—Conifer provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities.

Conifer's revenue cycle management solutions consist of: (1) patient services, including: centralized insurance and benefit verification; financial clearance, pre-certification, registration and check-in services; and financial counseling services, including reviews of eligibility for government healthcare or financial assistance programs, for both insured

and uninsured patients, as well as qualified health plan coverage under the ACA; (2) clinical revenue integrity solutions, including: clinical admission reviews; coding; clinical documentation improvement; coding compliance audits; charge description master management; and health information services; and (3) accounts receivable management solutions, including: third-party billing and collections; denials management; and patient collections. All of these solutions include ongoing measurement and monitoring of key revenue cycle metrics, as well as productivity and quality improvement programs. These revenue cycle management solutions assist hospitals, physician practices and other healthcare organizations in improving cash flow, revenue, and physician and patient satisfaction.

In addition, Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referral requests, calls regarding maternity services and other patient inquiries, (2) community education and

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outreach, and (3) scheduling and appointment reminders. Additionally, Conifer coordinates and implements marketing outreach programs to keep patients informed of screenings, seminars and other events and services.

Conifer also offers value-based care solutions, including clinical integration, financial risk management and population health management, all of which assist hospitals, physicians, ACOs, health plans, self-insured employers and government agencies in improving the cost and quality of healthcare delivery, as well as patient outcomes. Conifer helps clients build clinically integrated networks that provide predictive analytics and quality measures across the care continuum. In addition, Conifer helps clients align and manage financial incentives among healthcare stakeholders through risk modeling and administration of various payment models. Furthermore, Conifer offers clients tools and analytics to improve quality of care and provide care management services for patients with chronic diseases by identifying high-risk patients, coordinating with patients and clinicians in managing care, and monitoring clinical outcomes.

Clients—At December 31, 2018, Conifer provided one or more of the business process services described above to approximately 750 clients nationwide. Tenet and CHI facilities represented over 300 of these clients, and the remainder were unaffiliated healthcare systems, hospitals, physician practices, self-insured organizations, health plans and other entities. The agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer, were initially scheduled to expire in December 2018. As we continue to pursue strategic alternatives for Conifer, these agreements were renewed for an additional year with substantially similar pricing terms; however, the pricing or other material terms of such agreements may be modified if any such strategic alternative is consummated. Conifer's agreement with CHI to provide patient access, revenue integrity and patient financial services to CHI's facilities expires in 2032. For the year ended December 31, 2018, approximately 38% of Conifer's net operating revenues were attributable to its relationship with Tenet and approximately 36% were attributable to its relationship with CHI. Additional information about our Conifer operating segment can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

As we explore a sale or other strategic alternatives for Conifer, we are continuing to market Conifer's revenue cycle management, patient communications and engagement services, and value-based care solutions businesses. The uncertainty regarding our plans for Conifer may have an adverse impact on our ability to secure new clients for Conifer. However, we believe that our success in growing Conifer and increasing its profitability depends in part on our success in executing the following strategies: (1) attracting hospitals and other healthcare providers that currently handle their revenue cycle management processes internally as new clients; (2) generating new client relationships through opportunities from USPI and Tenet's acute care hospital acquisition and divestiture activities; (3) expanding revenue cycle management and value-based care service offerings through organic development and small acquisitions; (4) leveraging data from tens of millions of patient interactions for continued enhancement of the value-based care environment to drive competitive differentiation; and (5) developing services for our Ambulatory Care segment, leveraging USPI's capabilities. There can be no assurance that Conifer will be successful in generating new client relationships, particularly with respect to hospitals we or Conifer's other clients sell, as the respective buyers of such hospitals may not continue to use Conifer's services or, if they do, they may not do so under the same contractual terms.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2018 are set forth in the table beginning on page 3. We lease the majority of our outpatient facilities in both our Hospital Operations and other segment and our Ambulatory Care segment. These leases typically have initial terms ranging from five to 20 years, and most of the leases contain options to extend the lease periods. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own many of these

medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

Our corporate headquarters are located in Dallas, Texas. In addition, we maintain administrative offices in markets where we operate hospitals and other businesses, including USPI and Conifer. We typically lease our office space under operating lease agreements. We believe that all of our properties are suitable for their respective uses and are, in general, adequate for our present needs.

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. However, third parties may develop intellectual property that is similar or superior to ours. We also license third-party software, other technology and certain trademarks through agreements that impose certain restrictions on our ability to use the licensed items. We control access to and use of our software and other technology

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through a combination of internal and external controls. Although we do not believe the intellectual property we utilize infringes any intellectual property right held by a third party, we could be prevented from utilizing such property and could be subject to significant damage awards if our use is found to do so.

PHYSICIANS AND EMPLOYEES

Physicians—Our operations depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and other facilities, as well as physicians who affiliate with us and use our facilities as an extension of their practices. Under state laws and other licensing standards, medical staffs are generally self-governing organizations subject to ultimate oversight by the facility's local governing board. Members of the medical staffs of our facilities also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our facilities or admit their patients to competing facilities at any time. At December 31, 2018, we owned over 740 physician practices, and we employed (where permitted by state law) or otherwise affiliated with nearly 1,600 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals and outpatient centers. It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Moreover, our ability to recruit and employ physicians is closely regulated.

Employees in Our Healthcare Facilities—In addition to physicians, the operations of our facilities are dependent on the efforts, abilities and experience of our facilities management and medical support employees, including nurses, therapists, pharmacists and lab technicians. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the day-to-day operations of our facilities. In some markets, there is a limited availability of experienced medical support personnel, which drives up the local wages and benefits required to recruit and retain employees. In particular, like others in the healthcare industry, we continue to experience a shortage of critical-care nurses in certain disciplines and geographic areas. Moreover, we hire many newly licensed nurses in addition to experienced nurses, which requires us to invest in their training.

California is the only state in which we operate that requires minimum nurse-to-patient staffing ratios to be maintained at all times in acute care hospitals. If other states in which we operate adopt mandatory nurse-staffing ratios, it could have a significant effect on our labor costs and have an adverse impact on our net operating revenues if we are required to limit patient volumes in order to meet the required ratios.

Union Activity and Labor Relations—At December 31, 2018, approximately 26% of the employees in our Hospital Operations and other segment were represented by labor unions. Less than 1% of the employees in our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 35 of our hospitals, the majority of which are in California, Florida and Michigan. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is a possibility that strikes could occur, and our continued operation during any strikes could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods, which could result in increases in salaries, wages and benefits expense.

Headcount—At December 31, 2018, we employed approximately 115,500 people (of which approximately 22% were part-time employees) in our three business segments, as follows:

Hospital Operations and other	85,010
Ambulatory Care	17,710

Conifer	12,780
Total	**115,500**

COMPETITION

HEALTHCARE SERVICES

Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, our competitors (1) may offer a broader array of services or more desirable facilities to patients and physicians than ours, (2) may have larger or

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more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, (4) may be more centrally located with better parking or closer proximity to public transportation or (5) may be able to negotiate more favorable reimbursement rates that they may use to strengthen their competitive position. In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies, as well as health insurers and private equity companies seeking to acquire providers, in specific geographic markets.

We also face competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high-margin services and for quality physicians and personnel. In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic imaging centers in the geographic areas in which we operate has increased significantly. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations. These tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. In addition, in certain markets in which we operate, large teaching hospitals provide highly specialized facilities, equipment and services that may not be available at our hospitals.

Another major factor in the competitive position of a hospital or outpatient facility is the ability to negotiate contracts with managed care plans. Health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), third-party administrators, and other third-party payers use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals’ established charges. These negotiated discounts generally limit our ability to increase charges in response to increasing costs. Nevertheless, our future success depends, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on competitive terms. Other healthcare providers may affect our ability to enter into acceptable managed care contractual arrangements or negotiate increases in our reimbursement. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Furthermore, the ongoing trend toward consolidation among non-government payers tends to increase their bargaining power over fee structures.

In addition, the competitive positions of hospitals and outpatient facilities depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of those facilities, as well as physicians who affiliate with and use outpatient centers as an extension of their practices. Members of the medical staffs of our facilities also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our facilities or admit their patients to competing facilities at any time. State laws that require findings of need for construction and expansion of healthcare facilities or services (as described in “Healthcare Regulation and Licensing – Certificate of Need Requirements” below) may also impact competition.

Our strategies are designed to help our hospitals and outpatient facilities remain competitive. We believe emphasis on higher-demand clinical service lines (including outpatient lines) and improved quality metrics will improve our volumes. Furthermore, we have expanded our ambulatory care business, and we have significantly increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, increased predictability and efficiency for physicians, and (for most services) lower costs for payers than would be incurred with a hospital visit. We have also sought to include all of our hospitals and other healthcare businesses in the related geographic area or nationally when negotiating new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks.

We have made significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of other physicians on the medical staff,

the location of the hospital, and the quality of the hospital's facilities, equipment and employees. 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 more appropriate lengths of stay, as well as reductions in readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effects of: (1) reducing costs; (2) increasing payments from Medicare and certain managed care payers for our services as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others; and (3) increasing physician and patient satisfaction, which may improve our volumes.

Moreover, in most of our markets, we have formed clinically integrated networks, 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

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or other risk-sharing model. However, we do face competition from other healthcare systems that are implementing similar physician alignment strategies, such as employing physicians, acquiring physician practice groups, and participating in ACOs or other clinical integration models.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Our Conifer subsidiary faces competition from existing participants and new entrants to the revenue cycle management market, some of which may have significantly greater capital resources than Conifer. In addition, the internal revenue cycle management staff of hospitals and other healthcare providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions may choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, including:

- software vendors and other technology-supported revenue cycle management business process outsourcing companies;
- traditional consultants, either specialized healthcare consulting firms or healthcare divisions of large accounting firms; and
- large, non-healthcare focused business process and information technology outsourcing firms.

We believe that competition for the revenue cycle management and other services Conifer provides is based primarily on: (1) knowledge and understanding of the complex public and private healthcare payment and reimbursement systems; (2) a track record of delivering revenue improvements and efficiency gains for hospitals and other healthcare providers; (3) the ability to deliver solutions that are fully integrated along each step of the revenue cycle; (4) cost-effectiveness, including the breakdown between up-front costs and pay-for-performance incentive compensation; (5) reliability, simplicity and flexibility of the technology platform; (6) understanding of the healthcare industry's regulatory environment, as well as laws and regulations relating to consumer protection; and (7) financial resources to maintain current technology and other infrastructure.

To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and client requirements. Existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential clients might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition has resulted and may continue to result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share. In addition, the uncertainty regarding our plans for Conifer may have an adverse impact on Conifer's ability to secure new clients.

HEALTHCARE REGULATION AND LICENSING

HEALTHCARE REFORM

The Affordable Care Act extended health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. To fund the expansion of insurance coverage, the ACA includes measures designed to promote quality and cost efficiency in healthcare delivery and to generate budgetary savings in the Medicare and Medicaid programs. In addition, the ACA contains provisions intended to strengthen fraud and abuse enforcement.

The initial expansion of health insurance coverage under the ACA resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as result, our revenues has historically been derived from government healthcare programs, reductions to our reimbursement under the Medicare and Medicaid programs as a result of the ACA have been partially offset by increased revenues from providing care to previously uninsured individuals.

The President issued an executive order in January 2017 declaring that it is the official policy of his administration to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations. In October 2017, the administration announced that reimbursements to insurance companies for ACA cost-sharing

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reduction ("CSR") plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, many insurers increased premiums for plans offered on ACA exchanges and a few withdrew entirely from offering plans on some of the exchanges. In addition, in December 2017, Congress passed and the President signed a tax reform bill into law that, among other things, eliminates the ACA's individual mandate penalty for not buying health insurance starting in 2019. The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that eliminating the mandate penalty starting in 2019 – and making no other changes to the then-current law – would cause the number of people with health insurance to decrease by 4 million in 2019 and 13 million in 2027. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. We cannot predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

There have also been successful judicial challenges to the ACA, including a December 2018 ruling by the U.S. District Court for the Northern District of Texas that the ACA's individual mandate is unconstitutional. Because the judge's order was stayed pending appeal, the decision's near-term impact on health insurance coverage under the ACA may be limited; however, uncertainty over the future of the ACA has intensified. The ultimate outcome of this decision and other judicial challenges is indeterminate. We are also unable to predict the impact of administrative, regulatory and legislative changes, and market reactions to those changes, on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in Medicare reimbursement and reductions in Medicare disproportionate share hospital ("DSH") payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions scheduled to take effect in federal fiscal years 2020 through 2025) are made.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Anti-Kickback Statute—Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute") prohibit certain business practices and relationships that might affect the provision and cost of healthcare services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program. Moreover, the Affordable Care Act amended the Anti-kickback Statute to provide that intent to violate the Anti-kickback Statute is not required; rather, intent to violate the law generally is all that is required.

Sanctions for violating the Anti-kickback Statute include criminal and civil penalties, as well as fines and mandatory exclusion from government programs, such as Medicare and Medicaid. In addition, submission of a claim for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act ("FCA"). Furthermore, it is a violation of the federal Civil Monetary Penalties Law to offer or transfer anything of value to Medicare or Medicaid beneficiaries that is likely to influence their decision to obtain covered goods or services from one provider or service over another. Many states have statutes similar to the federal Anti-kickback Statute, except that the state statutes usually apply to referrals for services reimbursed by all third-party payers, not just federal programs.

The federal government has also issued regulations that describe some of the conduct and business relationships that are permissible under the Anti-kickback Statute. These regulations are often referred to as the “Safe Harbor” regulations. Currently, there are safe harbors for various activities, including the following: investment interests; space rental; equipment rental; practitioner recruitment; personal services and management contracts; sales of practices; referral services; warranties; discounts; employees; group purchasing organizations; waivers of beneficiary coinsurance and deductible amounts; managed care arrangements; obstetrical malpractice insurance subsidies; investments in group practices; ambulatory surgery centers; referral agreements for specialty services; cost-sharing waivers for pharmacies and emergency ambulance services; and local transportation. The fact that certain conduct or a given business arrangement does not meet a Safe Harbor does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. Rather, such conduct and business arrangements may be subject to increased scrutiny by government enforcement authorities and should be reviewed on a case-by-case basis.

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Stark Law—The Stark law generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined "designated health services," such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services; the prohibition does not apply to health services provided by an ambulatory surgery center if those services are included in the surgery center's composite Medicare payment rate. However, if the ambulatory surgery center is separately billing Medicare for designated health services that are not covered under the ambulatory surgery center's composite Medicare payment rate, or if either the ambulatory surgery center or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ambulatory surgery center service, the Stark law's self-referral prohibition would apply and such services could implicate the Stark law. Exceptions to the Stark law's referral prohibition cover a broad range of common financial relationships. These statutory and the subsequent regulatory exceptions are available to protect certain permitted employment relationships, relocation arrangements, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

The Affordable Care Act also made changes to the "whole hospital" exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in then-existing physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital had physician ownership and a Medicare provider agreement as of March 23, 2010 (or, for those hospitals under development at the time of the ACA's enactment, as of December 31, 2010). A physician-owned hospital that meets these requirements is still subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for hospitals with a high percentage of Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. Physician-owned hospitals are also currently subject to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements.

Implications of Fraud and Abuse Laws—At December 31, 2018, the majority of the facilities that operate as surgical hospitals in our Ambulatory Care segment are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals. Furthermore, the majority of ambulatory surgery centers in our Ambulatory Care segment, which are owned by joint ventures with physicians or healthcare systems, are subject to the Anti-kickback Statute and, in certain circumstances, may be subject to the Stark law. In addition, we have contracts with physicians and non-physician referral services providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements, such as medical director agreements. We have also provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-kickback Statute, the Stark law, billing requirements, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. For example, we cannot predict whether physicians may ultimately be restricted from holding ownership interests in hospitals or whether the exception relating to services provided by ambulatory surgery centers could be eliminated. We are continuing to enter into new financial arrangements with physicians and other providers in a manner we believe complies with applicable anti-kickback and anti-fraud and abuse laws. However, governmental officials responsible for enforcing these laws may nevertheless assert that we are in violation of these provisions. In addition, these statutes or regulations may be interpreted and enforced by the courts in a manner that is not consistent with our interpretation. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare,

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Medicaid or other federal healthcare programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that USPI or its subsidiaries has violated any of these laws could give certain of our healthcare system partners a right to terminate their relationships with us; and any similar determination with respect to Conifer or any of its subsidiaries could give Conifer's clients the right to terminate their services agreements with us. Moreover, any violations by and resulting penalties or exclusions imposed upon USPI's healthcare system partners or Conifer's clients could adversely affect their financial condition and, in turn, have a material adverse effect on our business and results of operations.

Retention of Independent Compliance Monitor—In September 2016, the Company and certain of its subsidiaries, including Tenet HealthSystem Medical, Inc. ("THSMI"), Atlanta Medical Center, Inc. ("AMCI") and North Fulton Medical Center, Inc. ("NFMCI"), executed agreements with the U.S. Department of Justice ("DOJ") and others to resolve a civil qui tam action and criminal investigation. In accordance with the terms of the resolution agreements, THSMI entered into a Non-Prosecution Agreement (as amended, the "NPA") with the Criminal Division, Fraud Section, of the DOJ and the U.S. Attorney's Office for the Northern District of Georgia (together, the "Offices"). The NPA requires, among other things, (1) THSMI and the Company to fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, and (2) the Company to retain an independent compliance monitor to assess, oversee and monitor its compliance with the obligations under the NPA. The powers, duties and responsibilities of the independent compliance monitor are broadly defined. On February 1, 2017, the Company retained two independent co-monitors (the "Monitor"), who are partners in a national law firm.

The Monitor's primary responsibility is to assess, oversee and monitor the Company's compliance with its obligations under the NPA to specifically address and reduce the risk of any recurrence of violations of the Anti-kickback Statute and Stark law by any entity the Company owns, in whole or in part. In doing so, the Monitor reviews and monitors the effectiveness of the Company's compliance with the Anti-kickback Statute and the Stark law, as well as respective implementing regulations, advisories and advisory opinions promulgated thereunder, and makes such recommendations as the Monitor believes are necessary to comply with the NPA. With respect to all entities in which the Company or one of its affiliates owns a direct or indirect equity interest of 50% or less and does not manage or control the day-to-day operations, the Monitor's access to such entities is co-extensive with the Company's access or control and for the purpose of reviewing the conduct. During its term, the Monitor will review and provide recommendations for improving compliance with the Anti-kickback Statute and Stark law, as well as the design, implementation and enforcement of the Company's compliance and ethics programs for the purpose of preventing future criminal and ethical violations by the Company and its subsidiaries, including, but not limited to, violations related to the conduct giving rise to the NPA and the Criminal Information filed in connection with the NPA. If we are alleged or found to have violated the terms of the NPA described above or federal healthcare laws, rules or regulations in the future, our business, financial condition, results of operations or cash flows could be materially adversely affected. For additional information regarding the duties and authorities of the Monitor, reference is made to our Current Report on Form 8-K filed with the U.S. Securities and Exchange Commission ("SEC") on October 3, 2016.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Title II, Subtitle F of the Health Insurance Portability and Accountability Act mandates the adoption of specific standards for electronic transactions and code sets that are used to transmit certain types of health information. HIPAA's objective is to encourage efficiency and reduce the cost of operations within the healthcare industry. To protect the information transmitted using the mandated standards and the patient information used in the daily operations of a covered entity, HIPAA also sets forth federal rules protecting the privacy and security of protected health information ("PHI"). The privacy and security regulations address the use and disclosure of individually identifiable health information and the rights of patients to understand and control how their information is used and disclosed. The law provides both criminal and civil fines and penalties for covered entities that fail to comply with

HIPAA.

To receive reimbursement from CMS for electronic claims, healthcare providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain healthcare information electronically. Our electronic data transmissions are compliant with current HHS standards for additional electronic transactions and with HHS' operating rules to promote uniformity in the implementation of each standardized electronic transaction.

Under HIPAA, covered entities must establish administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic PHI maintained or transmitted by them or by others on their behalf. The covered entities we operate are in material compliance with the privacy, security and National Provider Identifier requirements of HIPAA. In addition, most of Conifer's clients are covered entities, and Conifer is a business associate to many of those clients under HIPAA as a result of its contractual obligations to perform certain functions on behalf of and provide certain

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services to those clients. As a business associate, Conifer's use and disclosure of PHI is restricted by HIPAA and the business associate agreements Conifer is required to enter into with its covered entity clients.

The Health Information Technology for Economic and Clinical Health ("HITECH") Act imposed certain of the HIPAA privacy and security requirements directly upon business associates of covered entities and significantly increased the monetary penalties for violations of HIPAA. Regulations also require business associates such as Conifer to notify covered entities, who in turn must notify affected individuals and government authorities, of data security breaches involving unsecured PHI. Since the passage of the HITECH Act, enforcement of HIPAA violations has increased. If Conifer knowingly breaches the HIPAA privacy and security requirements made applicable to business associates by the HITECH Act, it could expose Conifer to criminal liability (as well as contractual liability to the associated covered entity); a breach of safeguards and processes that is not due to reasonable cause or involves willful neglect could expose Conifer to significant civil penalties and the possibility of civil litigation under HIPAA and applicable state law.

We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA, and similar state privacy laws, under the guidance of our ethics and compliance department. Our compliance officers and information security officers are responsible for implementing and monitoring compliance with our HIPAA privacy and security policies and procedures throughout our company. We have also created an internal web-based HIPAA training program, which is mandatory for all employees. Based on existing regulations and our experience with HIPAA to this point, we continue to believe that the ongoing costs of complying with HIPAA will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the healthcare industry. The Office of Inspector General ("OIG") was established as an independent and objective oversight unit of HHS to carry out the mission of preventing fraud and abuse and promoting economy, efficiency and effectiveness of HHS programs and operations. In furtherance of this mission, the OIG, among other things, conducts audits, evaluations and investigations relating to HHS programs and operations and, when appropriate, imposes civil monetary penalties, assessments and administrative sanctions. Although we have extensive policies and procedures in place to facilitate compliance with the laws, rules and regulations affecting the healthcare industry, these policies and procedures may not be effective.

Healthcare providers are also subject to qui tam or "whistleblower" lawsuits under the FCA, which allows private individuals to bring actions on behalf of the government, alleging that a hospital or healthcare provider has defrauded a government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the qui tam plaintiff may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. It is a violation of the FCA to knowingly fail to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. Qui tam actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies. We have paid significant

amounts to resolve qui tam matters brought against us in the past, and we are unable to predict the impact of future qui tam actions on our business, financial condition, results of operations or cash flows.

HEALTHCARE FACILITY LICENSING REQUIREMENTS

The operation of healthcare facilities is subject to federal, state and local regulations relating to personnel, operating policies and procedures, fire prevention, rate-setting, the adequacy of medical care, and compliance with building codes and environmental protection laws. Various licenses and permits also are required in order to dispense narcotics, operate pharmacies, handle radioactive materials and operate certain equipment. Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditation. We believe that all of our healthcare facilities hold all required governmental approvals, licenses and permits material to the operation of their business.

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UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

In addition to certain statutory coverage limits and exclusions, federal regulations, specifically the Medicare Conditions of Participation, generally require healthcare providers, including hospitals that furnish or order healthcare services that may be paid for under the Medicare program or state healthcare programs, to ensure that claims for reimbursement are for services or items that are (1) provided economically and only when, and to the extent, they are medically reasonable and necessary, (2) of a quality that meets professionally recognized standards of healthcare, and (3) supported by appropriate evidence of medical necessity and quality. The Social Security Act established the Utilization and Quality Control Peer Review Organization program, now known as the Quality Improvement Organization ("QIO") program, to promote the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. CMS administers the program through a network of QIOs that work with consumers, physicians, hospitals and other caregivers to refine care delivery systems to ensure patients receive the appropriate care at the appropriate time, particularly among underserved populations. The QIO program also safeguards the integrity of the Medicare trust fund by reviewing Medicare patient admissions, treatments and discharges, and ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care. The QIOs have the authority to deny payment for services provided and recommend to HHS that a provider that is in substantial noncompliance with certain standards be excluded from participating in the Medicare program.

There has been increased scrutiny from outside auditors, government enforcement agencies and others, as well as an increased risk of government investigations and qui tam lawsuits, related to hospitals' Medicare observation rates and inpatient admission decisions. The term "Medicare observation rate" is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In addition, CMS has established a concept referred to as the "two-midnight rule" to guide practitioners admitting patients and contractors on when it is appropriate to admit individuals as hospital inpatients. Under the two-midnight rule, a Medicare patient should generally be admitted on an inpatient basis only when there is a reasonable expectation that the patient's care will cross two midnights; if not, the patient generally should be treated as an outpatient, unless an exception applies. In our affiliated hospitals, we conduct reviews of Medicare inpatient stays of less than two midnights to determine whether a patient qualifies for inpatient admission. Enforcement of the two-midnight rule has not had, and is not expected to have, a material impact on inpatient admission rates at our hospitals.

Medical and surgical services and practices are extensively supervised by committees of staff doctors at each of our healthcare facilities, are overseen by each facility's local governing board, the members of which primarily are community members and physicians, and are reviewed by our clinical quality personnel. The local governing board also helps maintain standards for quality care, develop short-term and long-range plans, and establish, review and enforce practices and procedures, as well as approves the credentials, disciplining and, if necessary, the termination of privileges of medical staff members.

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates or determinations of need, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Our subsidiaries operate hospitals in six states that require a form of state approval under certificate of need programs applicable to those hospitals. Approximately 71% of our licensed hospital beds are located in these states (namely,

Alabama, Florida, Massachusetts, Michigan, South Carolina and Tennessee). The certificate of need programs in most of these states, along with several others, also apply to ambulatory surgery centers.

Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license. We are unable to predict whether we will be required or able to obtain any additional certificates of need in any jurisdiction where they are required, or if any jurisdiction will eliminate or alter its certificate of need requirements in a manner that will increase competition and, thereby, affect our competitive position. In those states that do not have certificate of need requirements or that do not require review of healthcare capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

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ENVIRONMENTAL MATTERS

Our healthcare operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with statutes and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows. There were no material capital expenditures for environmental matters in the year ended December 31, 2018.

ANTITRUST LAWS

The federal government and most states have enacted antitrust laws that prohibit specific types of anti-competitive conduct, including price fixing, wage fixing, anticompetitive hiring practices, concerted refusals to deal, price discrimination and tying arrangements, as well as monopolization and acquisitions of competitors that have, or may have, a substantial adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties.

Antitrust enforcement in the healthcare industry is currently a priority of the U.S. Federal Trade Commission (“FTC”). In recent years, the FTC has filed multiple administrative complaints and public comments challenging hospital transactions in several states. The FTC has focused its enforcement efforts on preventing hospital mergers that may, in the government’s view, leave insufficient local options for patient services. In addition to hospital merger enforcement, the FTC has given increased attention to the effect of combinations involving other healthcare providers, including physician practices. The FTC has also entered into numerous consent decrees in the past several years settling allegations of price-fixing among providers.

REGULATIONS AFFECTING CONIFER’S OPERATIONS

Conifer and its subsidiaries are subject to civil and criminal statutes and regulations governing consumer finance, medical billing, coding, collections and other operations. In connection with these laws and regulations, Conifer and its subsidiaries have been and expect to continue to be party to various lawsuits, claims, and federal and state regulatory investigations from time to time. Some of these actions may involve large demands, as well as substantial defense costs. We cannot predict the outcome of current or future legal actions against Conifer and its subsidiaries or the effect that judgments, penalties or settlements in such matters may have on Conifer.

BILLING AND COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act (“FDCPA”) regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by Conifer’s third-party debt collection vendors are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. Conifer audits and monitors its vendors for

compliance, but there can be no assurance that such audits and monitoring will detect all instances of potential non-compliance.

Many states also regulate the billing and collection practices of creditors who collect their own debt, as well as the companies a creditor engages to bill and collect from consumers on the creditor's behalf. These state regulations may be more stringent than the FDCPA. In addition, state regulations may be specific to medical billing and collections or the same or similar to state regulations applicable to third-party collectors. Certain of the accounts receivable Conifer or its billing, servicing and collections subsidiary, PSS Patient Solution Services, LLC, manages for its clients are subject to these state regulations.

Conifer and its subsidiaries are also subject to both federal and state regulatory agencies who have the authority to investigate consumer complaints relating to a variety of consumer protection laws, including but not limited to the Telephone Consumer Protection Act and its state equivalent. These agencies may initiate enforcement actions, including actions to seek

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restitution and monetary penalties from, or to require changes in business practices of, regulated entities. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

PAYMENT ACTIVITY RISKS

Conifer accepts payments from patients of the facilities for which it provides services using a variety of methods, including credit card, debit card, direct debit from a patient's bank account, and physical bank check. For certain payment methods, including credit and debit cards, Conifer pays interchange and other fees, which may increase over time, thereby raising operating costs. Conifer relies on third parties to provide payment processing services, including the processing of credit cards, debit cards and electronic checks, and it could disrupt Conifer's business if these companies become unwilling or unable to provide these services. Conifer is also subject to payment card association operating rules, including data security rules, certification requirements and rules governing electronic funds transfers, which could change or be reinterpreted to make it difficult or impossible for Conifer to comply. If Conifer fails to comply with these rules or requirements, or if its data security systems are breached or compromised, Conifer may be liable for card issuing banks' costs, be subject to fines and higher transaction fees, and lose its ability to accept credit and debit card payments from patients, process electronic funds transfers, or facilitate other types of online payments.

COMPLIANCE AND ETHICS

General—Our ethics and compliance department maintains our values-based ethics and compliance program, which is designed to (1) help staff in our corporate, USPI and Conifer offices, hospitals, outpatient centers and physician practices meet or exceed applicable standards established by federal and state statutes and regulations, as well as industry practice, (2) monitor and raise awareness of ethical issues among employees and others, and stress the importance of understanding and complying with our *Standards of Conduct*, and (3) provide a channel for employees to make confidential ethics and compliance-related reports anonymously if they choose. The ethics and compliance department operates independently – it has its own operating budget; it has the authority to hire outside counsel, access any company document and interview any of our personnel; and our chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

Program Charter—Our *Quality, Compliance and Ethics Program Charter* is the governing document for our ethics and compliance program. Our adherence to the charter is intended to:

- support and maintain our present and future responsibilities with regard to participation in federal healthcare programs; and
- further our goals of operating an organization that (1) fosters and maintains the highest ethical standards among all employees, officers and directors, physicians practicing at our facilities and contractors that furnish healthcare items or services, (2) values compliance with all state and federal statutes and regulations as a foundation of its corporate philosophy, and (3) aligns its behaviors and decisions with Tenet's core values of quality, integrity, service, innovation and transparency.

The primary focus of our quality, compliance and ethics program is compliance with the requirements of Medicare, Medicaid and other federally funded healthcare programs. Pursuant to the terms of the charter, our ethics and compliance department is responsible for, among other things, the following activities: (1) ensuring, in collaboration with in-house counsel, facilitation of the Monitor's activities and compliance with the provisions of the NPA and related company policies; (2) assessing, critiquing, and (as appropriate) drafting and distributing company policies and procedures; (3) developing, providing, and tracking ethics and compliance training and other training programs, including job-specific training to those who work in clinical quality, coding, billing, cost reporting and referral source

arrangements, in collaboration with the respective department responsible for oversight of each of these areas; (4) creating and disseminating the Company's *Standards of Conduct* and obtaining certifications of adherence to the *Standards of Conduct* as a condition of employment; (5) maintaining and promoting the Company's Ethics Action Line, a 24-hour, toll-free hotline that allows for confidential reporting of issues on an anonymous basis and emphasizes the Company's no-retaliation policy; and (6) responding to and ensuring resolution of all compliance-related issues that arise from the Ethics Action Line and compliance reports received from facilities and compliance officers (utilizing any compliance reporting software that the Company may employ for this purpose) or any other source that results in a report to the ethics and compliance department.

Standards of Conduct—All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our *Standards of Conduct* to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and all of our contractors having functional

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roles similar to our employees are also required to abide by our *Standards of Conduct*. The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable statutes and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

As part of the program, we provide training sessions at least annually to every employee, as well as our board of directors and certain physicians and contractors. All employees are required to report incidents that they believe in good faith may be in violation of the *Standards of Conduct* or our policies, and are encouraged to contact our Ethics Action Line when they have questions about the standards or any ethics concerns. All reports to the Ethics Action Line are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. Incidents of alleged financial improprieties reported to the Ethics Action Line or the ethics and compliance department are communicated to the audit committee of our board of directors. Reported cases that involve a possible violation of the law or regulatory policies and procedures are referred to the ethics and compliance department for investigation, although certain matters may be referred out to the law department. Retaliation against employees in connection with reporting ethical concerns is considered a serious violation of our *Standards of Conduct*, and, if it occurs, it will result in discipline, up to and including termination of employment.

Non-Prosecution Agreement—In September 2016, our THSMI subsidiary entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia. The NPA requires, among other things, that we and THSMI (1) fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, (2) retain an independent compliance monitor to assess, oversee and monitor our compliance with the obligations under the NPA, (3) promptly report any evidence or allegations of actual or potential violations of the Anti-kickback Statute, (4) maintain our compliance and ethics program throughout our operations, including those of our subsidiaries, affiliates, agents and joint ventures (to the extent that we manage or control or THSMI manages or controls such joint ventures), and (5) notify the DOJ and undertake certain other obligations specified in the NPA relative to, among other things, any sale, merger or transfer of all or substantially all of our and THSMI's respective business operations or the business operations of our or its subsidiaries or affiliates, including an obligation to include in any contract for sale, merger, transfer or other change in corporate form a provision binding the purchaser to retain the commitment of us or THSMI, or any successor-in-interest thereto, to comply with the NPA obligations except as may otherwise be agreed by the parties to the NPA in connection with a particular transaction. Except as may otherwise be agreed by the parties in connection with a particular transaction, if, during the term of the NPA, THSMI undertakes or we undertake any change in corporate form that involves business operations that are material to our consolidated operations or to the operations of any subsidiaries or affiliates involved in the conduct described in the NPA, whether such transaction is structured as a sale, asset sale, merger, transfer or other change in corporate form, we are required to provide notice to the Offices at least 30 days prior to undertaking any such change in corporate form.

The NPA was originally scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained); however, the DOJ subsequently extended the expiration date of the NPA by nine months to November 1, 2020 following its determination that we had breached certain reporting obligations under the terms of the NPA. In the event the Offices determine, in their sole discretion, that the Company, or any of its subsidiaries or affiliates, has knowingly violated any provision of the NPA, the NPA could be further extended by the Offices, in their sole discretion without prejudice to the Offices' other rights under the NPA. Conversely, in the event the Offices find, in their sole discretion, that there exists a change in circumstances sufficient to eliminate the need for a monitor, or that the other provisions of the NPA have been satisfied, the oversight of the Monitor or the NPA itself may be terminated early.

If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal healthcare programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. The NPA provides that, in the event the DOJ determines that the Company or THSMI has breached the NPA, the DOJ will provide written notice prior to instituting any prosecution of the Company or THSMI resulting from such breach. Following receipt of such notice, the Company and THSMI have the opportunity to respond to the DOJ to explain the nature and circumstances of the breach, as well as the actions taken to address and remediate the situation, which the DOJ shall consider in determining whether to pursue prosecution of the Company, THSMI or its affiliates. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Availability of Documents—The full text of our *Quality, Compliance and Ethics Program Charter,* our *Standards of Conduct*, and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the “Our Commitment To Compliance” caption in the “About Us” section. A copy of our

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Standards of Conduct is also available upon written request to our corporate secretary. Information about how to contact our corporate secretary is set forth under "Company Information" below. Amendments to the *Standards of Conduct* and any grant of a waiver from a provision of the *Standards of Conduct* requiring disclosure under applicable SEC rules will be disclosed at the same location as the *Standards of Conduct* on our website. A copy of the NPA is attached as an exhibit to our Current Report on Form 8-K filed with the SEC on October 3, 2016, and the letter agreement amending the term of the NPA, which was finalized on June 1, 2018, is attached as an exhibit to our Report on Form 10-Q for the quarter ended June 30, 2018.

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. For the policy periods April 1, 2017 through March 31, 2018 and April 1, 2018 through March 31, 2019, we have coverage totaling $850 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million for floods, $200 million for earthquakes and a per-occurrence sub-limit of $200 million for named windstorms with no annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and named windstorms, the total $850 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for California earthquakes, floods and named windstorms, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Floods and certain other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Insurance—As is typical in the healthcare industry, we are subject to claims and lawsuits in the ordinary course of business. The healthcare industry has seen significant increases in the cost of professional liability insurance due to increased litigation. In response, we maintain captive insurance companies to self-insure a substantial portion of our professional and general liability risk. We also own a captive insurance company that writes professional liability insurance for a small number of physicians, including employed physicians, who are on the medical staffs of certain of our hospitals.

Claims in excess of our self-insurance retentions are insured with commercial insurance companies. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital.

In addition to the reserves recorded by our captive insurance subsidiaries, we maintain reserves, including reserves for incurred but not reported claims, for our self-insured professional liability retentions and claims in excess of the policies' aggregate limits, based on modeled estimates of losses and related expenses. Also, we provide standby letters of credit to certain of our insurers, which can be drawn upon under certain circumstances, to collateralize the deductible and self-insured retentions under a selected number of our professional and general liability insurance programs.

COMPANY INFORMATION

Tenet Healthcare Corporation was incorporated in the State of Nevada in 1975. We file annual, quarterly and current reports, proxy statements and other documents with the SEC under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Our reports, proxy statements and other documents filed electronically with the SEC are available at the website maintained by the SEC at www.sec.gov.

Our website, www.tenethealth.com, also offers, free of charge, access to our annual, quarterly and current reports (and amendments to such reports), and other filings made with, or furnished to, the SEC as soon as reasonably practicable after such documents are submitted to the SEC. The information found on our website is not part of this or any other report we file with or furnish to the SEC.

Inquiries directed to our corporate secretary may be sent to Corporate Secretary, Tenet Healthcare Corporation, P.O. Box 139003, Dallas, Texas 75313-9003 or by e-mail at CorporateSecretary@tenethealth.com.

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EXECUTIVE OFFICERS

Information about our executive officers, as of February 25, 2019, is as follows:

Name	Position	Age
Ronald A. Rittenmeyer	Executive Chairman and Chief Executive Officer	71
Saumya Sutaria, M.D.	Chief Operating Officer	46
Daniel J. Cancelmi	Chief Financial Officer	56
Keith B. Pitts	Vice Chairman	61
Audrey T. Andrews	Senior Vice President and General Counsel	52

Mr. Rittenmeyer was named Tenet's executive chairman in August 2017 and chief executive officer in October 2017. He has served on Tenet's board of directors since 2010, most recently as lead director. He previously served as chairman of the board and chief executive officer of Millennium Health, a health solutions company. He served as the chairman, president and chief executive officer of Expert Global Solutions, Inc., a provider of business process outsourcing services, from 2011 to 2014. From 2005 to 2008, Mr. Rittenmeyer held a number of senior management positions with Electronic Data Systems Corporation, including chairman and chief executive officer from 2007 to 2008, president from 2006 to 2008, chief operating officer from 2005 to 2007 and executive vice president, global service delivery, from 2005 to 2006. Prior to that, he was a managing director of the Cypress Group, a private equity firm, serving from 2004 to 2005. He served as chairman, chief executive officer and president of Safety-Kleen Corp. from 2001 to 2004. Among his other leadership roles, Mr. Rittenmeyer served as chief executive officer and president of AmeriServe Food Distribution Inc. from 2000 to 2001, chairman, chief executive officer and president of RailTex, Inc. from 1998 to 2000, president and chief operating officer of Ryder TRS, Inc. from 1997 to 1998, president and chief operating officer of Merisel, Inc. from 1995 to 1996 and chief operating officer of Burlington Northern Railroad Co. from 1994 to 1995. Mr. Rittenmeyer received his bachelor of science degree in commerce and economics from Wilkes University and his M.B.A. from Rockhurst University. He is chairman of the Federation of American Hospitals' board of directors, and he currently serves on the board of directors of two other public companies: American International Group, Inc. and IQVIA Holdings Inc.

Dr. Sutaria was appointed Tenet's chief operating officer in January 2019. In this role, he oversees all of Tenet's acute care hospitals and hospital-affiliated outpatient facilities and physician practices. He also leads other functions across the enterprise within Tenet, USPI and Conifer. Prior to joining the Company, Dr. Sutaria worked for McKinsey & Company for 18 years, most recently as a Senior Partner providing advisory support for hospitals, healthcare systems, physicians groups, ambulatory care models, integrated delivery, and government-led delivery, while also working with institutional investors in healthcare. He previously held an associate clinical faculty appointment at the University of California at San Francisco, where he also engaged in postgraduate training with a focus in internal medicine and cardiology. Dr. Sutaria received his bachelor's degree in molecular and cellular biology and his bachelor's degree in economics, both from the University of California, Berkeley, as well as his M.D. from the University of California, San Diego.

Mr. Cancelmi was appointed Tenet's chief financial officer in September 2012. He previously served as senior vice president from April 2009, principal accounting officer from April 2007 and controller from September 2004. Mr. Cancelmi was a vice president and assistant controller at Tenet from September 1999 until his promotion to controller. He joined the Company as chief financial officer of Hahnemann University Hospital. Prior to that, he held various positions at PricewaterhouseCoopers, including in the firm's National Accounting and SEC office in New York City. Mr. Cancelmi is a certified public accountant who received his bachelor's degree in accounting from Duquesne University in Pittsburgh. He is also a member of the American Institute of Certified Public Accountants and

the Florida and Pennsylvania Institutes of Certified Public Accountants.

Mr. Pitts was appointed vice chairman following Tenet's acquisition of Vanguard Health Systems, Inc. ("Vanguard") in October 2013. He was Vanguard's vice chairman from May 2001 until the acquisition and an executive vice president from August 1999 until May 2001. Mr. Pitts also served as a director of Vanguard from August 1999 until September 2004. Before joining Vanguard, Mr. Pitts was the chairman and chief executive officer of Mariner Post-Acute Network and its predecessor, Paragon Health Network, a nursing home management company, from November 1997 until June 1999. He served as the executive vice president and chief financial officer for OrNda HealthCorp, prior to its acquisition by Tenet, from August 1992 to January 1997, and, before that, as a consultant to many healthcare organizations, including as a partner in Ernst & Young's healthcare consulting practice. Mr. Pitts is a certified public accountant who received his bachelor's degree in business administration from the University of Florida. He is a member of the American Institute of Certified Public Accountants and the Florida Institute of Certified Public Accountants.

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Ms. Andrews was appointed senior vice president and general counsel in January 2013. In this capacity, she oversees the law department and government relations for Tenet, USPI and Conifer. From July 2008 through December 2012, she served as senior vice president and chief compliance officer and, prior to that, served as vice president and chief compliance officer from November 2006. She joined Tenet in 1998 as hospital operations counsel. Ms. Andrews received her J.D. and her bachelor's degree in government, both from the University of Texas at Austin. She is a member of the American and Texas Bar Associations and the American Health Lawyers Association.

FORWARD-LOOKING STATEMENTS

This report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements, including (but not limited to) disclosure regarding our future earnings, financial position, operational and strategic initiatives, and developments in the healthcare industry. Forward-looking statements represent management's expectations, based on currently available information, as to the outcome and timing of future events, but, by their nature, address matters that are indeterminate. 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 to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the following:

- Our ability to achieve operating and financial targets, attain expected levels of patient volumes, and identify and execute on measures designed to save or control costs or streamline operations, including our ability to realize savings under our cost-reduction initiatives;

- The outcome of the process we have undertaken to explore a sale of or other strategic alternatives for Conifer;

- Potential disruptions to our business or diverted management attention as a result of the Conifer strategic review process or our cost-reduction efforts, including our plans to outsource certain functions unrelated to direct patient care;

- The impact on our business of recent and future modifications of or judicial challenges to the Affordable Care Act and the enactment of, or changes in, other statutes and regulations affecting the healthcare industry generally;

- Cuts to Medicare and Medicaid payment rates or changes in reimbursement practices or to Medicaid supplemental payment programs;

- Adverse regulatory developments, government investigations or litigation;

- Adverse developments with respect to our ability to comply with the terms of the Non-Prosecution Agreement, including any breach of the agreement;

- Our ability to enter into or renew managed care provider arrangements on acceptable terms; and changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under managed care agreements;

- The effect that adverse economic conditions, consumer behavior and other factors have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things; and increases in the amount of uninsured accounts and deductibles and copays for insured accounts;

- Our success in completing acquisitions, divestitures and other corporate development transactions; and our success in entering into, and managing the relationships and risks associated with, joint ventures;

- Our success in recruiting and retaining physicians and other healthcare professionals;

- The impact of competition on all aspects of our business;

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- The impact of our significant indebtedness; the availability and terms of capital to refinance existing debt, fund our operations and expand our business; and our ability to comply with our debt covenants and, over time, reduce leverage;

- Potential security threats, catastrophic events and other disruptions affecting our information technology and related systems;

- The timing and impact of additional changes in federal tax laws, regulations and policies, and the outcome of pending and any future tax audits, disputes and litigation associated with our tax positions; and

- Other factors and risks referenced in this report and our other public filings.

When considering forward-looking statements, you should keep in mind the risk factors and other cautionary statements in this report. Should one or more of the risks and uncertainties described in this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statement. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety, except as required by law.

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

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties, many of which are beyond our control, that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in this report were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment. Additional risks and uncertainties not presently known, or currently deemed immaterial, may also constrain our business and operations.

We cannot predict the impact that modifications of the Affordable Care Act may have on our business, financial condition, results of operations or cash flows.

The initial expansion of health insurance coverage under the Affordable Care Act resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as result, our revenues has historically been derived from government healthcare programs, reductions to our reimbursement under the Medicare and Medicaid programs as a result of the ACA have been partially offset by increased revenues from providing care to previously uninsured individuals.

The President issued an executive order in January 2017 declaring that it is the official policy of his administration to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations. In October 2017, the administration announced that reimbursements to insurance companies for ACA cost-sharing reduction plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, many insurers increased premiums for plans offered on ACA exchanges and a few withdrew entirely from offering plans on

some of the exchanges. In addition, in December 2017, Congress passed and the President signed a tax reform bill into law that, among other things, eliminates the ACA's individual mandate penalty for not buying health insurance starting in 2019. The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that eliminating the mandate penalty starting in 2019 – and making no other changes to the then-current law – would cause the number of people with health insurance to decrease by 4 million in 2019 and 13 million in 2027. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. We cannot predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law.

Furthermore, there have also been successful judicial challenges to the ACA, including a December 2018 ruling by the U.S. District Court for the Northern District of Texas that the ACA's individual mandate is unconstitutional. Because the judge's order was stayed pending appeal, the decision's near-term impact on health insurance coverage under the ACA may be limited; however, uncertainty over the future of the ACA has intensified. The ultimate outcome of this decision and other

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judicial challenges is indeterminate. We are also unable to predict the impact of administrative, regulatory and legislative changes, and market reactions to those changes, on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in Medicare reimbursement and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions scheduled to take effect in federal fiscal years 2020 through 2025) are made.

Further changes in the Medicare and Medicaid programs or other government healthcare programs, including reductions in scale and scope, could have an adverse effect on our business.

For the year ended December 31, 2018, approximately 20% and 9% of our net patient service revenues from our hospitals and related outpatient facilities were from the Medicare program and various state Medicaid programs, respectively, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows.

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 have received federal government waivers allowing them to test new approaches and demonstration projects to improve care. The timing of federal approval of these state-based Medicaid provider fee revenue programs – particularly the California provider fee program – may have an impact on our net operating revenues and cash flows in any given period. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays, changes to Medicaid supplemental payment programs or additional taxes on hospitals.

In general, we are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government healthcare program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

Our business and financial results could be harmed if we are alleged to have violated existing regulations or if we fail to comply with new or changed regulations.

Our hospitals, outpatient centers and related healthcare businesses are subject to extensive federal, state and local regulation relating to, among other things, licensure, contractual arrangements, conduct of operations, privacy of patient information, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the healthcare industry are extremely complex and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. Moreover, under the ACA, the government and its contractors may suspend Medicare and Medicaid payments to providers of

services “pending an investigation of a credible allegation of fraud.” The potential consequences for violating such laws, rules or regulations include reimbursement of government program payments, the assessment of civil monetary penalties, including treble damages, fines, which could be significant, exclusion from participation in federal healthcare programs, or criminal sanctions against current or former employees, any of which could have a material adverse effect on our business, financial condition or cash flows. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on the value of our common stock and our business reputation could suffer.

Furthermore, healthcare, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local healthcare regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively

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affecting healthcare providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

As we explore outsourcing and offshoring of certain functions unrelated to direct patient care to enhance efficiency, we must ensure that those operations will be compliant with U.S. healthcare industry-specific requirements. In addition, we are required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

Conifer and its subsidiaries are subject to numerous federal, state and local consumer protection and other laws governing such topics as privacy, financial services, and billing and collections activities. Regulations governing Conifer's operations are subject to changing interpretations that may be inconsistent among different jurisdictions. In addition, a regulatory determination made by, or a settlement or consent decree entered into with, one regulatory agency may not be binding upon, or preclude, investigations or regulatory actions by other agencies. Conifer's failure to comply with applicable consumer protection and other laws could result in, among other things, the issuance of cease and desist orders (which can include orders for restitution or rescission of contracts, as well as other kinds of affirmative relief), the imposition of fines or refunds, and other civil and criminal penalties, some of which could be significant in the case of knowing or reckless violations. In addition, Conifer's failure to comply with the statutes and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its clients, give clients the right to terminate Conifer's services agreements with them or give rise to contractual liabilities, among other things, any of which could have a material adverse effect on Conifer's business. Furthermore, if Conifer or its subsidiaries become subject to fines or other penalties, it could harm Conifer's reputation, thereby making it more difficult for Conifer to retain existing clients or attract new clients.

If we breach or otherwise fail to comply with our Non-Prosecution Agreement, we could be subject to criminal prosecution, substantial penalties and exclusion from participation in federal healthcare programs, any of which could adversely impact our business, financial condition, results of operations or cash flows.

In September 2016, one of our subsidiaries, Tenet HealthSystem Medical, Inc., entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia, as described in "Compliance and Ethics – Non-Prosecution Agreement" above. If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal healthcare programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We could be subject to substantial uninsured liabilities or increased insurance costs as a result of significant legal actions.

We are subject to medical malpractice lawsuits, antitrust and employment class action lawsuits, and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be subject to such caps. Our professional and general liability insurance does not cover all claims against us, and it may not continue to be available at a reasonable cost for us to maintain at adequate levels, as the healthcare industry has seen significant increases in the cost of such insurance due to increased litigation. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in

such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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If we are unable to enter into, maintain and renew managed care contractual arrangements on acceptable terms, if we experience material reductions in the contracted rates we receive from managed care payers or if we have difficulty collecting from managed care payers, our results of operations could be adversely affected.

The amount of our managed care net patient service revenues, including Medicare and Medicaid managed care programs, from our hospitals and related outpatient facilities during the year ended December 31, 2018 was approximately $9.2 billion, which represented approximately 65% of our total net patient service revenues. In addition, in the year ended December 31, 2018, our commercial managed care net inpatient revenue per admission from the hospitals and related outpatient facilities in our Hospital Operations and other segment was approximately 89% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. Our ability to negotiate favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans, as well as add new facilities to our existing agreements at contracted rates, significantly affects our revenues and operating results. We currently have thousands of managed care contracts with various HMOs and PPOs; however, our top ten managed care payers generated 65% of our managed care net patient service revenues for the year ended December 31, 2018. Because of this concentration, we may experience a short or long-term adverse effect on our net operating revenues if we cannot renew, replace or otherwise mitigate the impact of expired contracts with significant payers. Furthermore, any disputes between us and significant managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows. At December 31, 2018, 61% of our net accounts receivable for our Hospital Operations and other segment was due from managed care payers.

Private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. Any negotiated discount programs we agree to generally limit our ability to increase charges in response to increasing costs. Furthermore, the ongoing trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on competitive terms. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services or any significant difficulties in collecting receivables from managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows.

Our cost-reduction initiatives may not deliver the benefits we expect, and actions taken may adversely affect our business, financial condition and results of operations.

Our future financial performance and level of profitability is dependent, in part, on various cost-reduction initiatives, including a recently announced strategy to explore outsourcing certain functions unrelated to direct patient care. We may encounter challenges in executing our cost-reduction initiatives and not achieve the intended cost savings. In addition, we may face wrongful termination, discrimination or other legal claims from employees affected by any workforce reductions, and we may incur substantial costs defending against such claims, regardless of their merits. Such claims may also significantly increase our severance costs. Workforce reductions, whether as a result of internal restructuring or in connection with outsourcing efforts, may result in the loss of numerous long-term employees, the loss of institutional knowledge and expertise, the reallocation of certain job responsibilities and the disruption of business continuity, all of which could negatively affect operational efficiencies and increase our operating expenses in the short term. Moreover, outsourcing and offshoring may expose us to additional risks, such as reduced control over operational quality and timing, foreign political and economic instability, and compliance and regulatory challenges. Our failure to effectively execute our cost-reduction initiatives may lead to significant volatility, and a

decline, in the price of our common stock. We cannot guarantee that our cost-reduction initiatives will be successful, and we may need to take additional steps in the future to achieve our profitability goals.

We cannot provide any assurances that we will be successful in divesting assets in non-core markets or that we will complete the process we have initiated for the potential divestiture of or other transaction involving Conifer.

We continue to exit service lines, businesses and markets that we believe are no longer strategic to our long-term growth. To that end, in 2018 we divested eight hospitals in the United States, as well as all of our operations in the United Kingdom. In addition, in January 2019, we completed the previously announced sale of three hospitals in the Chicago area that we owned at December 31, 2018. We cannot provide any assurances that completed, planned or future divestitures will achieve their business goals or the cost and service synergies we expect. We also cannot predict the outcome of the process we have been exploring regarding strategic alternatives for Conifer, including a potential sale or merger, a tax-efficient spin-off or a combination of alternative transactions.

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With respect to all proposed divestitures of assets or businesses, we may fail to obtain applicable regulatory approvals for such divestitures, including any approval that may be required under our NPA. Moreover, we may encounter difficulties in finding acquirers or alternative exit strategies on terms that are favorable to us, which could delay the receipt of anticipated proceeds necessary for us to complete our planned strategic objectives. In addition, our divestiture activities have required, and may in the future require, us to retain significant pre-closing liabilities, recognize impairment charges (as discussed below) or agree to contractual restrictions that limit our ability to reenter the applicable market, which may be material. Furthermore, our divestiture or other corporate development activities may present financial and operational risks, including (1) the diversion of management attention from existing core businesses, (2) adverse effects (including a deterioration in the related asset or business and, in Conifer's case, the loss of existing clients and the difficulties associated with securing new clients) from the announcement of the planned or potential divestiture, and (3) the challenges associated with separating personnel and financial and other systems.

A divestiture or other separation of Conifer could adversely affect our earnings and cash flows.

Conifer contributes a significant portion of the Company's earnings and cash flows. We have been engaged in a process to consider a divestiture or other strategic alternatives for Conifer, such as a merger, a tax-efficient spin-off or a combination of alternative transactions. Although there can be no assurance that this process will result in a consummated transaction, any separation of all or a portion of Conifer's business could adversely affect our earnings and cash flows.

Economic factors, consumer behavior and other dynamics have affected, and may continue to impact, our business, financial condition and results of operations.

We believe broad economic factors (including high unemployment rates in some of the markets our facilities serve), instability in consumer spending, uncertainty regarding the future of the Affordable Care Act, and the continued shift of additional financial responsibility to insured patients through higher co-pays, deductibles and premium contributions, among other dynamics, have affected our service mix, revenue mix and volumes, as well as our ability to collect outstanding receivables. Any increase in the amount or deterioration in the collectability of patient accounts receivable will adversely affect our cash flows and results of operations. The U.S. economy remains unpredictable. If industry trends, such as reductions in commercial managed care enrollment and patient decisions to postpone or cancel elective and non-emergency healthcare procedures, worsen or if general economic conditions deteriorate, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Trends affecting our actual or anticipated results may require us to record charges that may negatively impact our results of operations.

As a result of factors that have negatively affected our industry generally and our business specifically, we have been required to record various charges in our results of operations. During the years ended December 31, 2018 and 2017, we recorded impairment charges of $77 million and $402 million, respectively. Our impairment tests presume stable, improving or, in some cases, declining operating results in our hospitals, which are based on programs and initiatives being implemented that are designed to achieve the hospitals' most recent projections. If these projections are not met, or negative trends occur that impact our future outlook, future impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material. Future restructuring of our operating structure that changes our goodwill reporting units could also result in future impairments of our goodwill. Any such charges could negatively impact our results of operations.

When we acquire new assets or businesses, we become subject to various risks and uncertainties that could adversely affect our results of operations and financial condition.

We have completed a number of acquisitions in recent years, and we expect to pursue similar transactions in the future. A key business strategy for USPI, in particular, is the acquisition and development of facilities, primarily through the formation of joint ventures with physicians and healthcare systems. With respect to planned or future transactions, we cannot provide any assurances that we will be able to identify suitable candidates, consummate transactions on terms that are favorable to us, or achieve synergies or other benefits in a timely manner or at all. Furthermore, companies or operations acquired may not be profitable or may not achieve the profitability that justifies the investments made. In addition, we may face significant challenges in integrating personnel and financial and other systems. Future acquisitions could result in potentially dilutive issuances of equity securities, the incurrence of additional debt and contingent liabilities, and increased operating expenses, any of which could adversely affect our results of operations and financial condition.

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USPI and our hospital-based joint ventures depend on existing relationships with key healthcare system partners. If we are unable to maintain historical relationships with these healthcare systems, or enter into new relationships, we may be unable to implement our business strategies successfully.

USPI and our hospital-based joint ventures depend in part on the efforts, reputations and success of healthcare system partners and the strength of our relationships with those healthcare systems. Our joint ventures could be adversely affected by any damage to those healthcare systems' reputations or to our relationships with them. In addition, damage to our business reputation could negatively impact the willingness of healthcare systems to enter into relationships with us or USPI. If we are unable to maintain existing arrangements on favorable terms or enter into relationships with additional healthcare system partners, we may be unable to implement our business strategies for our joint ventures successfully.

The remaining put/call arrangements associated with USPI, if settled in cash, will require us to utilize our cash flow or incur additional indebtedness to satisfy the payment obligations in respect of such arrangements.

As part of the formation of USPI in 2015, we entered into a put/call agreement with respect to the equity interests in USPI held by our joint venture partners at that time. During 2016, 2017 and 2018, we paid $1.473 billion in the aggregate to purchase additional shares of USPI to increase our ownership interest in USPI to 95%.

We have also entered into a separate put/call agreement (the "Baylor Put/Call Agreement") with respect to the remaining 5% outside ownership interest in USPI held by Baylor University Medical Center. Each year starting in 2021, Baylor may require us to purchase, or "put" to us, up to 33.3% of their total shares in USPI held as of January 1, 2017. In each year that Baylor does not put the full 33.3% of USPI's shares allowable, we may call the difference between the number of shares Baylor put and the maximum number of shares they could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of Baylor's ownership interest by 2024. In each case, we have the ability to choose whether to settle the purchase price for the Baylor put/call in cash or shares of our common stock.

The put and call arrangements described above, to the extent settled in cash, may require us to dedicate a substantial portion of our cash flow to satisfy our payment obligations in respect of such arrangements, which may reduce the amount of funds available for our operations, capital expenditures and corporate development activities. Similarly, we may be required to incur additional indebtedness to satisfy our payment obligations in respect of such arrangements, which could have important consequences to our business and operations, as described more fully below under "*Our level of indebtedness could, among other things, adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, and prevent us from meeting our obligations under the agreements relating to our indebtedness.*"

Our joint venture arrangements are subject to a number of operational risks that could have a material adverse effect on our business, results of operations and financial condition.

We have invested in a number of joint ventures with other entities when circumstances warranted the use of these structures, and we may form additional joint ventures in the future. These joint ventures may not be profitable or may not achieve the profitability that justifies the investments made. Furthermore, the nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our results could be adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate

from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our results could be adversely affected. In addition, our relationships with not-for-profit healthcare systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current revenue rulings published by the Internal Revenue Service, as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit healthcare systems and related joint venture arrangements.

Our participation in joint ventures is also subject to the risks that:

- We could experience an impasse on certain decisions because we do not have sole decision-making authority, which could require us to expend additional resources on resolving such impasses or potential disputes.

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- We may not be able to maintain good relationships with our joint venture partners (including healthcare systems), which could limit our future growth potential and could have an adverse effect on our business strategies.

- Our joint venture partners could have investment or operational goals that are not consistent with our corporate-wide objectives, including the timing, terms and strategies for investments or future growth opportunities.

- Our joint venture partners might become bankrupt, fail to fund their share of required capital contributions or fail to fulfill their other obligations as joint venture partners, which may require us to infuse our own capital into any such venture on behalf of the related joint venture partner or partners despite other competing uses for such capital.

- Many of our existing joint ventures require that one of our wholly owned affiliates provide a working capital line of credit to the joint venture, which could require us to allocate substantial financial resources to the joint venture potentially impacting our ability to fund our other short-term obligations.

- Some of our existing joint ventures require mandatory capital expenditures for the benefit of the applicable joint venture, which could limit our ability to expend funds on other corporate opportunities.

- Our joint venture partners may have exit rights that would require us to purchase their interests upon the occurrence of certain events or the passage of certain time periods, which could impact our financial condition by requiring us to incur additional indebtedness in order to complete such transactions or, alternatively, in some cases we may have the option to issue shares of our common stock to our joint venture partners to satisfy such obligations, which would dilute the ownership of our existing stockholders.

- Our joint venture partners may have competing interests in our markets that could create conflict of interest issues.

- Any sale or other disposition of our interest in a joint venture or underlying assets of the joint venture may require consents from our joint venture partners, which we may not be able to obtain.

- Certain corporate-wide or strategic transactions may also trigger other contractual rights held by a joint venture partner (including termination or liquidation rights) depending on how the transaction is structured, which could impact our ability to complete such transactions.

- Our joint venture arrangements that involve financial and ownership relationships with physicians and others who either refer or influence the referral of patients to our hospitals or other healthcare facilities are subject to greater regulatory scrutiny from government enforcement agencies. While we endeavor to comply with the applicable safe harbors under the Anti-kickback Statute, certain of our current arrangements, including joint venture arrangements, do not qualify for safe harbor protection.

It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians.

The success of our business depends in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and other facilities, as well as physicians who affiliate with us and use our facilities as an extension of their practices. Physicians are often not employees of the hospitals or surgery centers at which they practice. Members of the medical staffs of our facilities also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our facilities or admit their patients to competing facilities at any time. In addition, although physicians who own interests in our facilities are generally subject to agreements restricting them from owning an interest in competitive facilities, we may not learn of, or be unsuccessful in preventing, our physician partners from

acquiring interests in competitive facilities.

We expect to encounter increased competition from health insurers and private equity companies seeking to acquire providers in the markets where we operate physician practices and, where permitted by law, employ physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Furthermore, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. All arrangements with physicians must also be fair market value

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and commercially reasonable. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may choose not to refer patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

Our labor costs could be adversely affected by competition for staffing, the shortage of experienced nurses and labor union activity.

The operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, including nurses, therapists, pharmacists and lab technicians, as well as our employed physicians. We compete with other healthcare providers in recruiting and retaining employees, and, like others in the healthcare industry, we continue to experience a shortage of critical-care nurses in certain disciplines and geographic areas. As a result, from time to time, we may be required to enhance wages and benefits to recruit and retain experienced employees, make greater investments in education and training for newly licensed medical support personnel, or hire more expensive temporary or contract employees. Furthermore, state-mandated nurse-staffing ratios in California affect not only our labor costs, but, if we are unable to hire the necessary number of experienced nurses to meet the required ratios, they may also cause us to limit volumes, which would have a corresponding adverse effect on our net operating revenues. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Increased labor union activity is another factor that could adversely affect our labor costs. At December 31, 2018, approximately 26% of the employees in our Hospital Operations and other segment were represented by labor unions. Less than 1% of the employees in our Ambulatory Care and Conifer segments belong to a union. Unionized employees – primarily registered nurses and service, technical and maintenance workers – are located at 35 of our hospitals, the majority of which are in California, Florida and Michigan. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is a possibility that strikes could occur, and our continued operation during any strikes could increase our labor costs and have an adverse effect on our patient volumes and net operating revenues. Organizing activities by labor unions could increase our level of union representation in future periods, which could result in increases in salaries, wages and benefits expense.

Our hospitals, outpatient centers and other healthcare businesses operate in competitive environments, and competition in our markets can adversely affect patient volumes.

The healthcare business is highly competitive, and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, our competitors (1) are more established or newer than ours, (2) may offer a broader array of services or more desirable facilities to patients and physicians than ours, and (3) may have larger or more specialized medical staffs to admit and refer patients, among other things. Furthermore, healthcare consumers are now able to access hospital performance data on quality measures and patient satisfaction, as well as standard charges for services, to compare competing providers; if any of our hospitals achieve poor results (or results that are lower than our competitors) on quality measures or patient satisfaction surveys, or if our standard charges are or are perceived to be higher than our competitors, we may attract fewer patients. Additional quality measures and trends toward clinical or billing transparency may have an unanticipated impact on our competitive position and patient volumes.

In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies, as well as health insurers and private equity companies seeking to acquire providers, in specific geographic markets. We also face competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding

outpatient centers for market share in high margin services and for quality physicians and personnel. In recent years, the number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic imaging centers in the geographic areas in which we operate has increased significantly. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. If our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than we are, we may experience an overall decline in patient volumes.

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Conifer operates in a highly competitive industry, and its current or future competitors may be able to compete more effectively than Conifer does, which could have a material adverse effect on Conifer's margins, growth rate and market share.

As we explore a sale or other strategic alternatives for Conifer, we are continuing to market Conifer's revenue cycle management, patient communications and engagement services, and value-based care solutions businesses. The uncertainty regarding our plans for Conifer may have an adverse impact on Conifer's ability to secure new clients. There can be no assurance that Conifer will be successful in generating new client relationships, including with respect to hospitals we or Conifer's other clients sell, as the respective buyers of such hospitals may not continue to use Conifer's services or, if they do, they may not do so under the same contractual terms. The market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market, as well as from the staffs of hospitals and other healthcare providers who handle these processes internally. In addition, electronic medical record software vendors may expand into services offerings that compete with Conifer. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and client requirements. Moreover, existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential clients might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition has resulted and may continue to result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

Our level of indebtedness could, among other things, adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, and prevent us from meeting our obligations under the agreements relating to our indebtedness.

At December 31, 2018, we had approximately $14.8 billion of total long-term debt, as well as $95 million in standby letters of credit outstanding in the aggregate, under our senior secured revolving credit facility (as amended, "Credit Agreement") and our letter of credit facility agreement (as amended, "LC Facility"). Our Credit Agreement is collateralized by patient accounts receivable of substantially all of our domestic wholly owned acute care and specialty hospitals, and our LC Facility is guaranteed and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. From time to time, we expect to engage in additional capital market, bank credit and other financing activities, depending on our needs and financing alternatives available at that time.

The interest expense associated with our indebtedness offsets a substantial portion of our operating income. During 2018, our interest expense was $1.004 billion and represented 61% of our $1.647 billion of operating income. As a result, relatively small percentage changes in our operating income can result in a relatively large percentage change in our net income and earnings per share, both positively and negatively. In addition:

- Our substantial indebtedness may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt.
- We may be more vulnerable in the event of a deterioration in our business, in the healthcare industry or in the economy generally, or if federal or state governments substantially limit or reduce reimbursement under the Medicare or Medicaid programs.
- Our debt service obligations reduce the amount of funds available for our operations, capital expenditures and corporate development activities, and may make it more difficult for us to satisfy our financial obligations.

- Our substantial indebtedness could limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs.

- Our significant indebtedness may result in the market value of our stock being more volatile, potentially resulting in larger investment gains or losses for our shareholders, than the market value of the common stock of other companies that have a relatively smaller amount of indebtedness.

- A significant portion of our outstanding debt is either subject to early prepayment penalties, such as “make-whole premiums,” or is not currently callable. As a result, it may be costly to pursue debt repayment as a deleveraging strategy.

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Furthermore, our Credit Agreement, our LC Facility and the indentures governing our outstanding notes contain, and any future debt obligations may contain, covenants that, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. See "*Restrictive covenants in the agreements governing our indebtedness may adversely affect us*."

We may not be able to generate sufficient cash to service all of our indebtedness, and we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our indebtedness depends on our financial and operating performance, which is subject to prevailing economic and competitive conditions and to financial, business and other factors that may be beyond our control. We cannot assure you that we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

In addition, our ability to meet our debt service obligations is dependent upon the operating results of our subsidiaries and their ability to pay dividends or make other payments or advances to us. We hold most of our assets at, and conduct substantially all of our operations through, direct and indirect subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations, including payment on our outstanding debt. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. Our less than wholly owned subsidiaries may also be subject to restrictions on their ability to distribute cash to us in their financing or other agreements and, as a result, we may not be able to access their cash flows to service their respective debt obligations.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, including those required for operating our existing facilities, for integrating our historical acquisitions or for future corporate development activities, and such reduction or delay could continue for years. We also may be forced to sell assets or operations, seek additional capital, or restructure or refinance our indebtedness. We cannot assure you that we would be able to take any of these actions, that these actions would be successful and permit us to meet our scheduled debt service obligations, or that these actions would be permitted under the terms of our existing or future debt agreements, including our Credit Agreement, our LC Facility and the indentures governing our outstanding notes.

Restrictive covenants in the agreements governing our indebtedness may adversely affect us.

Our Credit Agreement, our LC Facility and the indentures governing our outstanding notes contain various covenants that, among other things, limit our ability and the ability of our subsidiaries to:

- incur, assume or guarantee additional indebtedness;
- incur liens;
- make certain investments;
- provide subsidiary guarantees;
- consummate asset sales;
- redeem debt that is subordinated in right of payment to outstanding indebtedness;

- enter into sale and lease-back transactions;

- enter into transactions with affiliates; and

- consolidate, merge or sell all or substantially all of our assets.

These restrictions are subject to a number of important exceptions and qualifications.

In addition, so long as any obligation or commitment is outstanding under our Credit Agreement and LC Facility, the terms of such facilities require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. Our ability to meet these restrictive covenants and financial ratio may be affected by events beyond our

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control, and we cannot assure you that we will meet those tests. These restrictions could limit our ability to obtain future financing, make acquisitions or needed capital expenditures, withstand economic downturns in our business or the economy in general, conduct operations or otherwise take advantage of business opportunities that may arise. In addition, a breach of any of these covenants could cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

Despite current indebtedness levels, we may be able to incur substantially more debt or otherwise increase our leverage. This could further exacerbate the risks described above.

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our Credit Agreement, our LC Facility and the indentures governing our outstanding notes. We may decide to incur additional secured or unsecured debt in the future to finance our operations and any judgments or settlements or for other business purposes. Similarly, if we continue to sell assets, including the potential divestiture of or other strategic alternative involving Conifer, and do not use the proceeds to repay debt, this could further increase our financial leverage.

Our Credit Agreement provides for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Based on our eligible receivables, $998 million was available for borrowing under the Credit Agreement at December 31, 2018. Our LC Facility provides for the issuance of standby and documentary letters of credit in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). At December 31, 2018, we had no cash borrowings outstanding under the Credit Agreement, and we had $95 million of standby letters of credit outstanding in the aggregate under the Credit Agreement and the LC Facility. If new indebtedness is added or our leverage increases, the related risks that we now face could intensify.

Our business could be negatively affected by security threats, catastrophic events and other disruptions affecting our information technology and related systems.

Information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive and confidential data, including protected health information, personally identifiable information, and our proprietary and confidential business performance data. We utilize electronic health records and other information technology in connection with all of our operations, including our billing and supply chain and labor management operations. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the integrity, security and availability of the data we process, transmit and store, the information technology and infrastructure we use have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. Attacks or breaches could impact the integrity, security or availability of data we process, transmit or store, or they could disrupt our information technology systems, devices or businesses. While we are not aware of having experienced a material breach of our systems, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we will be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, and invest in new technology designed to mitigate security risks. Furthermore, we have an increased risk of security breaches or compromised intellectual property rights as a result of outsourcing certain functions unrelated to direct patient care. Though we have insurance against some cyber-risks and attacks, it may not offset the impact of a material loss event.

Third parties to whom we outsource certain of our functions, or with whom our systems interface and who may, in some instances, store our sensitive and confidential data, are also subject to the risks outlined above and may not have or use controls effective to protect such information. A breach or attack affecting any of these third parties could similarly harm our business. Further, successful cyber-attacks at other healthcare services companies, whether or not we are impacted, could lead to a general loss of consumer confidence in our industry that could negatively affect us, including harming the market perception of the effectiveness of our security measures or of the healthcare industry in general, which could result in reduced use of our services.

Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, hurricane, telecommunications failure, ransomware attack, terrorist attack or other catastrophic event. Any breach or system interruption of our information systems or of third parties with access to our sensitive and confidential data could result in: the unauthorized disclosure, misuse or loss of such data; interruptions and delays in our normal business operations (including the collection of revenues); patient harm; potential liability under privacy, security, consumer protection or other applicable laws;

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regulatory penalties; and negative publicity and damage to our reputation. Any of these could have a material adverse effect on our business, financial position, results of operations or cash flows.

The utilization of our tax losses could be substantially limited if we experience an ownership change as defined in the Internal Revenue Code.

At December 31, 2018, we had federal net operating loss ("NOL") carryforwards of approximately $1.0 billion pre-tax available to offset future taxable income. These NOL carryforwards will expire in the years 2027 to 2034. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income that may be offset by the NOL carryforwards if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount of taxable income we generate in future periods. There is no assurance that we will be able to fully utilize the NOL carryforwards. Furthermore, we could be required to record a valuation allowance related to the amount of the NOL carryforwards that may not be realized, which could adversely impact our results of operations.

The industry trend toward value-based purchasing and alternative payment models may negatively impact our revenues.

Value-based purchasing and alternative payment model initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities, and may negatively impact our revenues if we are unable to meet expected quality standards. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions ("HACs"), unless the conditions were present at admission. Hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year receive reduced Medicare reimbursements. Moreover, the ACA prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

The ACA also created the CMS Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria. In 2015, CMS finalized a five-year bundled payment model, called the Comprehensive Care for Joint Replacement ("CJR") model, which includes hip and knee replacements, as well as

other major leg procedures. Seventeen hospitals in our Hospital Operations and other segment and four of USPI's surgical hospitals currently participate in the CJR model. In addition, 42 hospitals in our Hospital Operations and other segment and five of USPI's surgical hospitals participate in the CMS Bundled Payments for Care Improvement Advanced ("BPCIA") program that became effective October 1, 2018. USPI also holds the CMS contract for four physician group practices participating in the BPCIA program. We cannot predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

There is also a trend among private payers toward value-based purchasing and alternative payment models for healthcare services. Many large commercial payers expect hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts.

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We are unable at this time to predict how the industry trend toward value-based purchasing and alternative payment models will affect our results of operations, but it could negatively impact our revenues, particularly if we are unable to meet the quality and cost standards established by both governmental and private payers.

Our business and financial results could be harmed by a national or localized outbreak of a highly contagious or epidemic disease.

If an outbreak of an infectious disease, such as the Zika virus or the Ebola virus, were to occur nationally or in one of the regions our hospitals serve, our business and financial results could be adversely affected. The treatment of a highly contagious disease at one of our facilities may result in a temporary shutdown or diversion of patients. In addition, unaffected individuals may decide to defer elective procedures or otherwise avoid medical treatment, resulting in reduced patient volumes and operating revenues. Furthermore, we cannot predict the costs associated with the potential treatment of an infectious disease outbreak by our hospitals or preparation for such treatment.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The disclosure required under this Item is included in Item 1, Business, of Part I of this report.

ITEM 3. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 16 to our Consolidated Financial Statements, which is incorporated by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II.

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." As of February 15, 2019, there were holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

Equity Compensation. Refer to Item 12, Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters, of Part III of this report, as well as Note 9 to our Consolidated Financial Statements, for information regarding securities authorized for issuance under our equity compensation plans.

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to the following indices:

- Standard & Poor's 500 Stock Index (a broad equity market index in which we are not included);
- Standard & Poor's Health Care Composite Index (a published industry index in which we are not included); and
- A group made up of us and our hospital company peers (namely, Community Health Systems, Inc. (CYH), HCA Healthcare, Inc. (HCA), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS)), which we refer to as our "Peer Group". LifePoint Health, Inc. (LPNT), which was a member of our Peer Group index in prior years, is not included because it ceased having publicly traded equity securities in November 2018.

Performance data assumes that $100.00 was invested on December 31, 2013 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Moreover, in accordance with U.S. Securities and Exchange Commission ("SEC") regulations, the returns of each company in our Peer Group have been weighted according to the respective company's stock market capitalization at the beginning of each period for which a return is indicated. The stock price performance shown in the graph is not necessarily indicative of future stock price performance. The performance graph shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or incorporated by reference into any of our filings under the Securities Act of 1933, as amended, or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

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	12/13	12/14	12/15	12/16	12/17	12/18
Tenet Healthcare Corporation	$100.00	$120.30	$71.94	$35.23	$35.99	$40.69
S&P 500	$100.00	$113.69	$115.26	$129.05	$157.22	$150.33
S&P Health Care	$100.00	$125.34	$133.97	$130.37	$159.15	$169.44
Peer Group	$100.00	$145.00	$126.07	$119.47	$136.82	$180.80

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ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2014 through 2018. Effective January 1, 2018, we adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09") using a modified retrospective method of application to all contracts existing on January 1, 2018. For our Hospital and other and Ambulatory Care segments, the adoption of ASU 2014-09 resulted in changes to our presentation of revenue primarily related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. Under ASU 2014-09, the estimated uncollectable amounts due from these patients are generally considered implicit price concessions that are a direct reduction to net operating revenues, with a corresponding material reduction in the amounts presented separately as provision for doubtful accounts. Effective June 16, 2015, we completed a transaction that combined our freestanding ambulatory surgery and imaging center assets with the surgical facility assets of United Surgical Partners International, Inc. into a new joint venture called USPI Holding Company, Inc. ("USPI"). At December 31, 2018, we owned 95.0% of USPI. The tables below include USPI for the post-acquisition period only. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2018	2017	2016	2015	2014
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts		$20,613	$21,070	$20,111	$17,908
Less: Provision for doubtful accounts		1,434	1,449	1,477	1,305
Net operating revenues	**$18,313**	**19,179**	**19,621**	**18,634**	**16,603**
Equity in earnings of unconsolidated affiliates	**150**	**144**	**131**	**99**	**12**
Operating expenses:					
Salaries, wages and benefits	8,634	9,274	9,328	8,990	8,013
Supplies	3,004	3,085	3,124	2,963	2,630
Other operating expenses, net	4,259	4,570	4,891	4,555	4,114
Electronic health record incentives	(3)	(9)	(32)	(72)	(104)
Depreciation and amortization	802	870	850	797	849
Impairment and restructuring charges, and acquisition-related costs	209	541	202	318	153
Litigation and investigation costs	38	23	293	291	25
Net gains on sales, consolidation and deconsolidation of facilities	(127)	(144)	(151)	(186)	—
Operating income	**1,647**	**1,113**	**1,247**	**1,077**	**935**
Interest expense	(1,004)	(1,028)	(979)	(912)	(754)
Other non-operating expense, net	(5)	(22)	(20)	(20)	(10)
Gain (loss) from early extinguishment of debt	1	(164)	—	(1)	(24)
Income (loss) from continuing operations, before income taxes	**639**	**(101)**	**248**	**144**	**147**
Income tax expense	(176)	(219)	(67)	(68)	(49)
Income (loss) from continuing operations, before discontinued operations	**463**	**(320)**	**181**	**76**	**98**
Less: Net income available to noncontrolling interests from continuing operations	355	384	368	218	64
	$108	**$(704)**	**$(187)**	**$(142)**	**$34**

Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders from continuing operations					
Basic earnings available (loss attributable) per share to Tenet Healthcare Corporation common shareholders from continuing operations	**$1.06**	**$(7.00)**	**$(1.88)**	**$(1.43)**	**$0.35**
Diluted earnings available (loss attributable) per share to Tenet Healthcare Corporation common shareholders from continuing operations	**$1.04**	**$(7.00)**	**$(1.88)**	**$(1.43)**	**$0.34**

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The operating results data presented above is not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid 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 ("CMS") of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated implicit price concessions; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; 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; gains (losses) on sales, consolidation and deconsolidation of facilities; 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 (losses) from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect service mix, revenue mix, patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: changes in federal and state healthcare regulations; the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; hospital performance data on quality measures and patient satisfaction, as well as standard charges for services; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; and the timing of elective procedures.

BALANCE SHEET DATA

	December 31,				
	2018	2017	2016	2015	2014
	(In Millions)				
Working capital (current assets minus current liabilities)	$779	$1,241	$1,223	$ 863	$ 393
Total assets	22,409	23,385	24,701	23,682	17,951
Long-term debt, net of current portion	14,644	14,791	15,064	14,383	11,505
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,420	1,866	2,393	2,266	401
Noncontrolling interests	806	686	665	267	134
Total equity	687	539	1,082	958	785

CASH FLOW DATA

	Years Ended December 31,				
	2018	2017	2016	2015	2014
	(In Millions)				
Net cash provided by operating activities	$1,049	$1,200	$558	$1,026	$687
Net cash provided by (used in) investing activities	(115)	21	(430)	(1,317)	(1,322)
Net cash provided by (used in) financing activities	(1,134)	(1,326)	232	454	715

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ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our Hospital Operations and other segment is comprised of our acute care and specialty hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. As described in Note 5 to the accompanying Consolidated Financial Statements, certain of our facilities were classified as held for sale at December 31, 2018. Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI"), in which we own a 95% interest, and included nine European Surgical Partners Limited ("Aspen") facilities until their divestiture effective August 17, 2018. At December 31, 2018, USPI had interests in 255 ambulatory surgery centers, 36 urgent care centers, 23 imaging centers and 23 surgical hospitals in 27 states. Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities, through our Conifer Holdings, Inc. ("Conifer") subsidiary. Nearly all of the services comprising the operations of our Conifer segment are provided directly by Conifer Health Solutions, LLC, in which we owned 76.2% as of December 31, 2018, or by one of its direct or indirect wholly owned subsidiaries. MD&A, which should be read in conjunction with the accompanying Consolidated Financial Statements, includes the following sections:

- Management Overview
- Sources of Revenue for Our Hospital Operations and Other Segment
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Recently Issued Accounting Standards
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per admission, per adjusted patient admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 68 hospitals operated throughout the years ended December 31, 2018 and 2017, (ii) three Houston-area hospitals, which we divested effective August 1, 2017, (iii) Abrazo Maryvale Campus, which we closed in December 2017, (iv) two Philadelphia-area hospitals, which we divested effective January 11, 2018, (v) MacNeal Hospital, which we divested effective March 1, 2018 and (vi) Des Peres Hospital, which we divested effective May 1, 2018. The results of our Aspen facilities are included until August 17, 2018, the date of divestiture. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. In addition, although we operated four North Texas hospitals throughout the year ended December 31, 2017 and from January 1 through February 28, 2018 as part of a joint venture, we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Sale of Three Hospitals and Related Operations in Chicago Area—Effective January 28, 2019, we completed the sale of three hospitals and hospital-affiliated operations in the Chicago area. As a result of this transaction, we received net pre-tax cash proceeds of $42 million.

Debt Refinancing Transactions—On February 5, 2019, we sold $1.5 billion aggregate principal amount of 6.250% senior secured second lien notes, which will mature on February 1, 2027 (the "2027 Senior Secured Second Lien Notes"). We will pay interest on the 2027 Senior Secured Second Lien Notes semi-annually in arrears on February 1 and August 1 of each year, which payments will commence on August 1, 2019. The proceeds from the sale of the 2027 Senior Secured Second Lien Notes were used, after payment of fees and expenses, together with cash on hand and borrowings under our senior secured revolving credit facility, to fund the redemption of all $300 million aggregate principal amount of our outstanding 6.750% senior notes due 2020 and all $750 million aggregate principal amount of our outstanding 7.500% senior

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secured second lien notes due 2022, and will be used to fund the repayment upon maturity of all $468 million aggregate principal amount of our outstanding 5.500% senior unsecured notes due March 1, 2019. In connection with the redemptions, we expect to record a loss from early extinguishment of debt of approximately $47 million in the three months ending March 31, 2019, primarily related to the difference between the redemption prices and the par values of the notes, as well as the write-off of the associated unamortized issuance costs.

TRENDS AND STRATEGIES

The healthcare industry, in general, and the acute care hospital business, in particular, have been experiencing significant regulatory uncertainty based, in large part, on administrative, legislative and judicial efforts to significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA"). It is difficult to predict the full impact of regulatory uncertainty on our future revenues and operations. In addition, we believe that several key trends are shaping the demand for healthcare services: (1) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (2) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (3) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (4) consolidation continues across the entire healthcare sector.

Driving Growth in Our Hospital Systems—We are committed to better positioning our hospital systems and competing more effectively in the ever-evolving healthcare environment. We are focused on improving operational effectiveness, increasing capital efficiency and margins, enhancing patient satisfaction, growing our higher-acuity inpatient service lines, expanding patient access points, and exiting service lines, businesses and markets that we believe are no longer a core part of our long-term growth strategy. We have undertaken enterprise-wide cost reduction initiatives, comprised primarily of workforce reductions (including streamlining corporate overhead and centralized support functions), the renegotiation of contracts with suppliers and vendors, and the consolidation of office locations. We achieved our targeted savings in 2018, but are continuing to look for additional areas for savings. Most of the savings in 2018 were achieved through actions within both our Hospital Operations and other segment and our Conifer segment. In conjunction with these initiatives, we incurred restructuring charges related to employee severance payments of $68 million in the year ended December 31, 2018, and we expect to incur additional such restructuring charges in 2019.

Improving the Customer Care Experience—As consumers continue to become more engaged in managing their health, we recognize that understanding what matters most to them and earning their loyalty is imperative to our success. As such, we have enhanced our focus on treating our patients as traditional customers by: (1) establishing networks of physicians and facilities that provide convenient access to services across the care continuum; (2) expanding service lines aligned with growing community demand, including a focus on chronic disease patients; (3) offering greater affordability and predictability, including simplified admissions and discharge procedures, particularly in our outpatient centers; (4) improving our culture of service; and (5) creating health and benefit programs, patient education and health literacy materials that are customized to the needs of the communities we serve. Through these efforts, we intend to improve the customer care experience in every part of our operations.

Expansion of Our Ambulatory Care Segment—We remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We believe USPI's surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability, flexibility and convenience. Moreover, due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable at a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to increase. In addition, we have continued to grow our imaging and urgent care businesses through USPI to reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we

offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services.

Exploration of Strategic Alternatives for Conifer While Continuing to Drive Conifer's Growth—We previously announced a number of actions to support our goals of improving financial performance and enhancing shareholder value, including the exploration of a potential sale of Conifer. In addition to a potential sale, we are considering other strategic alternatives for Conifer, such as a merger, a tax efficient spin-off or a combination of alternative transactions. There can be no assurance that this process will result in any transaction.

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Conifer serves approximately 750 Tenet and non-Tenet hospital and other clients nationwide. In addition to providing revenue cycle management services to healthcare systems and physicians, Conifer provides support to both providers and self-insured employers seeking assistance with clinical integration, financial risk management and population health management. Conifer remains focused on driving growth by continuing to market and expand its revenue cycle management and value-based care solutions businesses.

Improving Profitability—We are focused on growing patient volumes and effective cost management as a means to improve profitability. We believe our inpatient admissions have been constrained in recent years by increased competition, utilization pressure by managed care organizations, new delivery models that are designed to lower the utilization of acute care hospital services, the effects of higher patient co-pays, co-insurance amounts and deductibles, changing consumer behavior, and adverse economic conditions and demographic trends in certain of our markets. However, we also believe that emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our ambulatory care business, cultivation of our culture of service, participation in Medicare Advantage health plans that are experiencing higher growth rates than traditional Medicare plans, and contracting strategies that create shared value with payers should help us grow our patient volumes over time. In 2019, we are continuing to explore new opportunities to enhance efficiency, including further integration of enterprise-wide centralized support functions, outsourcing certain functions unrelated to direct patient care, and reducing clinical and vendor contract variation.

Reducing Our Leverage—All of our outstanding long-term debt has a fixed rate of interest, and the maturity dates of our notes are staggered from 2020 through 2031. Although we believe that our capital structure minimizes the near-term impact of increased interest rates, and the staggered maturities of our debt allow us to refinance our debt over time, it is nonetheless our long-term objective to lower our ratio of debt-to-Adjusted EBITDA, primarily through more efficient capital allocation and Adjusted EBITDA growth, which should lower our refinancing risk and increase the potential for us to continue to use lower rate secured debt to refinance portions of our higher rate unsecured debt.

Our ability to execute on our strategies and respond to the aforementioned trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of this report.

RECENT RESULTS OF OPERATIONS

We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2018 and 2017 on a continuing operations basis, which includes the results of (i) our same 68 hospitals operated throughout the three months ended December 31, 2018 and 2017, (ii) three Houston-area hospitals, which we divested effective August 1, 2017, (iii) our Abrazo Maryvale Campus, which we closed in December 2017, (iv) two Philadelphia-area hospitals, which we divested effective January 11, 2018, (v) MacNeal Hospital, which we divested effective March 1, 2018, and (vi) Des Peres Hospital, which we divested effective May 1, 2018. Although we operated four North Texas hospitals throughout the year ended December 31, 2017 and from January 1 through February 28, 2018 as part of a joint venture, we did not consolidate the results of operations of these hospitals because we divested a controlling interest in them effective January 1, 2016. The following tables also show information about facilities in our Ambulatory Care segment that we control and, therefore, consolidate. The results of our Aspen facilities are included until August 17, 2018, the date of divestiture.

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Selected Operating Statistics	Continuing Operations Three Months Ended December 31, 2018	2017	Increase (Decrease)	
Hospital Operations and other – hospitals and related outpatient facilities				
Number of hospitals (at end of period)	68	72	(4)	(1)
Total admissions	170,407	186,185	(8.5)%	
Adjusted patient admissions(2)	308,113	332,642	(7.4)%	
Paying admissions (excludes charity and uninsured)	160,172	176,158	(9.1)%	
Charity and uninsured admissions	10,235	10,027	2.1 %	
Emergency department visits	649,544	711,268	(8.7)%	
Total surgeries	108,535	118,896	(8.7)%	
Patient days — total	779,728	857,728	(9.1)%	
Adjusted patient days(2)	1,383,372	1,505,130	(8.1)%	
Average length of stay (days)	4.58	4.61	(0.7)%	
Average licensed beds	17,935	19,320	(7.2)%	
Utilization of licensed beds(3)	47.3 %	48.3 %	(1.0)%	(1)
Total visits	1,734,523	1,901,864	(8.8)%	
Paying visits (excludes charity and uninsured)	1,617,970	1,777,790	(9.0)%	
Charity and uninsured visits	116,553	124,074	(6.1)%	
Ambulatory Care				
Total consolidated facilities (at end of period)	227	227	—	(1)
Total cases	499,803	488,046	2.4 %	

(1) The change is the difference between the 2018 and 2017 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 decreased by 15,778, or 8.5%, in the three months ended December 31, 2018 compared to the three months ended December 31, 2017, and total surgeries decreased by 10,361, or 8.7%, in the 2018 period compared to the 2017 period. Our emergency department visits decreased 8.7% in the three months ended December 31, 2018 compared to the same period in the prior year. Our volumes from continuing operations in the three months ended December 31, 2018 compared to the three months ended December 31, 2017 were negatively affected by the closure of our Abrazo Maryvale Campus in December 2017, the sale of our Philadelphia-area facilities effective January 11, 2018, the sale of MacNeal Hospital and affiliated operations effective March 1, 2018, and the sale of Des Peres Hospital and affiliated operations effective May 1, 2018. Our Ambulatory Care total cases increased 2.4% in the three months ended December 31, 2018 compared to the 2017 period.

	Continuing Operations		
	Three Months Ended December 31,		
Revenues	2018	2017	Increase (Decrease)
Net operating revenues			
Hospital Operations and other prior to inter-segment eliminations	$3,843	$4,194	(8.4)%
Ambulatory Care	554	545	1.7 %
Conifer	372	394	(5.6)%
Inter-segment eliminations	(150)	(155)	(3.2)%
Total	$4,619	$4,978	(7.2)%

Net operating revenues decreased by $359 million, or 7.2%, in the three months ended December 31, 2018 compared to the same period in 2017, primarily due to the sale and closure of facilities described above, as well as the decrease in net revenues from the California provider fee program. In the 2018 period, we recognized $64 million of net revenues from the California provider fee program compared to $267 million recognized in the 2017 period due to CMS' approval of the 2017 program in December of that year. For our Hospital Operations and other segment, the impact of lower volumes on net operating revenues was partially mitigated by improved managed care pricing.

Our accounts receivable days outstanding ("AR Days") from continuing operations were 56.8 days at December 31, 2018 and 55.8 days at December 31, 2017, compared to our target of less than 55 days. This calculation includes our Hospital Operations and other contract assets subsequent to the adoption of ASU 2014-09 effective January 1, 2018 and the

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accounts receivable of our Chicago-area facilities that have been classified in assets held for sale on our Consolidated Balance Sheet at December 31, 2018, and excludes (i) three Houston-area hospitals, which we divested effective August 1, 2017, (ii) Abrazo Maryvale Campus, which we closed in December 2017, (iii) two Philadelphia-area hospitals, which we divested effective January 11, 2018, (iv) MacNeal Hospital, which we divested effective March 1, 2018, (v) Des Peres Hospital, which we divested effective May 1, 2018, (vi) all nine Aspen facilities, which we divested effective August 17, 2018, (vii) health plan revenues, and (viii) our California provider fee revenues.

	Continuing Operations Three Months Ended December 31,		
Selected Operating Expenses	**2018**	**2017**	**Increase (Decrease)**
Hospital Operations and other			
Salaries, wages and benefits	$1,785	$1,887	(5.4)%
Supplies	641	685	(6.4)%
Other operating expenses	921	930	(1.0)%
Total	$3,347	$3,502	(4.4)%
Ambulatory Care			
Salaries, wages and benefits	$160	$165	(3.0)%
Supplies	114	113	0.9 %
Other operating expenses	84	93	(9.7)%
Total	$358	$371	(3.5)%
Conifer			
Salaries, wages and benefits	$211	$232	(9.1)%
Supplies	1	2	(50.0)%
Other operating expenses	73	81	(9.9)%
Total	$285	$315	(9.5)%
Total			
Salaries, wages and benefits	$2,156	$2,284	(5.6)%
Supplies	756	800	(5.5)%
Other operating expenses	1,078	1,104	(2.4)%
Total	$3,990	$4,188	(4.7)%
Rent/lease expense[1]			
Hospital Operations and other	$58	$59	(1.7)%
Ambulatory Care	20	20	— %
Conifer	4	5	(20.0)%
Total	$82	$84	(2.4)%

(1) Included in other operating expenses.

	Continuing Operations Three Months Ended December 31,		
Selected Operating Expenses per Adjusted Patient Admission	**2018**	**2017**	**Increase (Decrease)**
Hospital Operations and other			
Salaries, wages and benefits per adjusted patient admission[1]	$5,791	$5,662	2.3 %
Supplies per adjusted patient admission[1]	2,079	2,058	1.0 %
Other operating expenses per adjusted patient admission[1]	2,991	2,772	7.9 %
Total per adjusted patient admission	$10,861	$10,492	3.5 %

(1) Calculation excludes the expenses from our health plan businesses. 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 2.3% in the three months ended December 31, 2018 compared to the same period in 2017. This change is primarily due to the effect of lower volumes on operating leverage due to certain fixed staffing costs, annual merit increases for certain of our employees, increased accruals for annual incentive compensation and increased health benefits costs, partially offset by the impact of previously announced workforce reductions as part of our enterprise-wide cost reduction initiatives in the three months ended December 31, 2018 compared to the three months ended December 31, 2017.

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Supplies expense per adjusted patient admission increased 1.0% in the three months ended December 31, 2018 compared to the three months ended December 31, 2017. The change in supplies expense was primarily attributable to growth in our higher acuity supply-intensive surgical services, partially offset by the impact of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

Other operating expenses per adjusted patient admission increased by 7.9% in the three months ended December 31, 2018 compared to the prior-year period. This increase is primarily due to higher medical fees per adjusted patient admission, the effect of lower volumes on operating leverage due to certain fixed costs and increased malpractice expense for our Hospital Operations and other segment, which was $44 million higher in the 2018 period compared to the 2017 period. The 2018 period included an unfavorable adjustment of approximately $8 million from a 42 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $4 million from a 17 basis point increase in the interest rate in the 2017 period.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $411 million at December 31, 2018 compared to $500 million at September 30, 2018.

Significant cash flow items in the three months ended December 31, 2018 included:

- Net cash provided by operating activities before interest, taxes, discontinued operations and restructuring charges, acquisition-related costs, and litigation costs and settlements of $626 million;
- Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements of $50 million;
- Capital expenditures of $213 million;
- $16 million of payments for the purchases of businesses or joint venture interests;
- $84 million of payments for the purchase of equity investments;
- Proceeds from the sales of facilities and other assets of $45 million;
- Proceeds from sale of marketable securities, long-term investments and other assets of $34 million;
- Interest payments of $324 million;
- $32 million of payments to purchase $32 million aggregate principal amount of our 5.500% senior unsecured notes due 2019; and
- $71 million of distributions paid to noncontrolling interests.

Net cash provided by operating activities was $1.049 billion in the year ended December 31, 2018 compared to $1.200 billion in the year ended December 31, 2017. Key factors contributing to the change between the 2018 and 2017 periods include the following:

- An increase of $38 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;

- Decreased cash receipts of $31 million related to the California provider fee program;

- Additional interest payments of $37 million in the 2018 period primarily due to the six-month interest payment in January 2018 related to our 7.500% senior secured second lien notes due 2022, which were issued in December 2016, and changes in the timing of certain interest payments as a result of our refinancing transactions in 2017;

- Lower income tax payments of $31 million in the 2018 period;

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- Increased cash flows from our health plan businesses of $101 million due to cash outflows in the 2017 period resulting from the sales and wind-down of these businesses in 2017, compared to negligible cash flows in the 2018 period; and

- The timing of other working capital items, including $129 million of additional payments for professional and general liability claims and expenses in the 2018 period.

SOURCES OF REVENUE FOR OUR HOSPITAL OPERATIONS AND OTHER SEGMENT

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 following table shows the sources of net patient service revenues less implicit price concessions and provision for doubtful accounts for our hospitals and related outpatient facilities, expressed as percentages of net patient service revenues less implicit price concessions and provision for doubtful accounts from all sources:

	Years Ended December 31,		
Net Patient Service Revenues Less Implicit Price Concessions and Provision for Doubtful Accounts from:	**2018**	**2017**	**2016**
Medicare	20.5%	21.9%	22.4%
Medicaid	9.2 %	8.8 %	8.9 %
Managed care(1)	65.4%	64.6%	64.3%
Self-pay	0.7 %	0.6 %	0.4 %
Indemnity and other	4.2 %	4.1 %	4.0 %

(1) Includes Medicare and Medicaid managed care programs.

Our payer mix on an admissions basis for our hospitals and related outpatient facilities, expressed as a percentage of total admissions from all sources, is shown below:

	Years Ended December 31,		
Admissions from:	**2018**	**2017**	**2016**
Medicare	25.4%	26.0%	26.1%
Medicaid	6.3 %	6.5 %	7.0 %
Managed care(1)	59.7%	59.6%	59.2%
Self-pay	6.0 %	5.5 %	5.4 %
Indemnity and other	2.6 %	2.4 %	2.3 %

(1) Includes Medicare and Medicaid managed care programs.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services, an agency of the U.S. Department of Health and Human Services ("HHS"), is the single largest payer of healthcare services in the United States. Approximately 58 million individuals rely on healthcare benefits through Medicare, and approximately 73 million individuals are enrolled in Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and administered by CMS. Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, as well as certain younger people with certain disabilities and conditions, 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. Unlike Medicaid, the CHIP is limited in duration and requires the enactment of reauthorizing legislation. During the three months ended March 31, 2018, separate pieces of legislation were enacted extending CHIP funding for a total of ten years from federal fiscal year ("FFY") 2018 (which began on October 1, 2017) through FFY 2027.

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The Affordable Care Act

The expansion of Medicaid in the 36 states (including four in which we currently operate acute care hospitals) and the District of Columbia that have taken action to do so is financed through:

- negative adjustments to the annual market basket updates for the Medicare hospital inpatient and outpatient prospective payment systems, which began in 2010 and under current law expire on September 30, 2019, as well as additional negative "productivity adjustments" to the annual market basket updates, which began in 2011; and

- reductions to Medicare and Medicaid disproportionate share hospital ("DSH") payments, which began for Medicare payments in FFY 2014 and, under current law, are scheduled to commence for Medicaid payments on October 1, 2019.

In December 2017, Congress passed and the President signed a tax reform bill into law that, among other things, eliminates the ACA's individual mandate penalty for not buying health insurance starting in 2019. The Congressional Budget Office and the staff of the Joint Committee on Taxation estimated that eliminating the mandate penalty starting in 2019 – and making no other changes to the then-current law – would cause the number of people with health insurance to decrease by 4 million in 2019 and 13 million in 2027. Members of Congress have also proposed measures that would expand government-sponsored coverage, including single-payer proposals. We cannot predict if or when further modification of the ACA will occur or what action, if any, Congress might take with respect to eventually repealing and possibly replacing the law. Furthermore, there have also been successful judicial challenges to the ACA, including a December 2018 ruling by the U.S. District Court for the Northern District of Texas that the ACA's individual mandate is unconstitutional. Because the judge's order was stayed pending appeal, the decision's near-term impact on health insurance coverage under the ACA may be limited; however, uncertainty over the future of the ACA has intensified. The ultimate outcome of this decision and other judicial challenges is indeterminate. We are also unable to predict the impact of administrative, regulatory and legislative changes, and market reactions to those changes, on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we likely will experience decreased volumes, reduced revenues and an increase in uncompensated care, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in Medicare reimbursement and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions scheduled to take effect in FFYs 2020 through 2025, as described below) are made.

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 service revenues from continuing operations of the hospitals and related outpatient facilities in our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2018, 2017 and 2016 are set forth in the following table:

	Years Ended December 31,		
Revenue Descriptions	**2018**	**2017**	**2016**
Medicare severity-adjusted diagnosis-related group — operating	$1,526	$1,659	$1,705
Medicare severity-adjusted diagnosis-related group — capital	137	162	157
Outliers	83	89	77
Outpatient	748	762	787

Disproportionate share	228	265	293
Other[1]	160	306	367
Total Medicare net patient service revenues	**$2,882**	**$3,243**	**$3,386**

(1) The other revenue category includes Medicare Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") revenues, IME revenues earned by our children's hospitals (one of which we divested in 2018) under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS, inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital (which was divested in 2017), other revenue adjustments, and adjustments to the estimates for current and prior-year cost reports and related valuation allowances.

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

Acute Care Hospital Inpatient Prospective Payment System

Medicare Severity-Adjusted Diagnosis-Related Group Payments—Sections 1886(d) and 1886(g) of the Social Security Act (the "Act") set forth a system of payments for the operating and capital costs of inpatient acute care hospital admissions based on a prospective payment system ("PPS"). Under the inpatient prospective payment systems ("IPPS"), Medicare payments for hospital inpatient operating services are made at predetermined rates for each hospital discharge. Discharges are classified according to a system of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), which categorize patients with similar clinical characteristics that are expected to require similar amounts of hospital resources. CMS assigns to each MS-DRG a relative weight that represents the average resources required to treat cases in that particular MS-DRG, relative to the average resources used to treat cases in all MS-DRGs.

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. Using diagnosis and procedure information submitted by the hospital, CMS assigns to each discharge an MS-DRG, and the base payments are multiplied by the relative weight of the MS-DRG assigned. The MS-DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not take into consideration an individual hospital's operating and capital costs.

Outlier Payments—Outlier payments are additional payments made to hospitals on individual claims for treating Medicare patients whose medical conditions are costlier to treat than those of the average patient in the same MS-DRG. To qualify for a cost outlier payment, a hospital's billed charges, adjusted to cost, must exceed the payment rate for the MS-DRG by a fixed threshold established annually by CMS. A Medicare Administrative Contractor ("MAC") calculates the cost of a claim by multiplying the billed charges by a cost-to-charge ratio that is typically based on the hospital's most recently filed cost report. Generally, if the computed cost exceeds the sum of the MS-DRG payment plus the fixed threshold, the hospital receives 80% of the difference as an outlier payment.

Under the Act, CMS must project aggregate annual outlier payments to all PPS hospitals to be not less than 5% or more than 6% of total MS-DRG payments ("Outlier Percentage"). The Outlier Percentage is determined by dividing total outlier payments by the sum of MS-DRG and outlier payments. CMS annually adjusts the fixed threshold to bring projected outlier payments within the mandated limit. A change to the fixed threshold affects total outlier payments by changing: (1) the number of cases that qualify for outlier payments; and (2) the dollar amount hospitals receive for those cases that qualify for outlier payments.

Disproportionate Share Hospital Payments—In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately high share of low-income patients. Prior to October 1, 2013, DSH payments were determined annually based on certain statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. The ACA revised the Medicare DSH adjustment effective for discharges occurring on or after October 1, 2013. Under the revised methodology, hospitals receive 25% of the amount they previously would have received under the pre-ACA formula. This amount is referred to as the "Empirically Justified Amount."

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the “UC DSH Amount”). The UC DSH Amount is a hospital’s share of a pool of funds that the CMS Office of the Actuary estimates would equal 75% of Medicare DSH that otherwise would have been paid under the pre-ACA formula, adjusted for changes in the percentage of individuals that are uninsured. Generally, the factors used to calculate and distribute UC DSH Amounts are set forth in the ACA and are not subject to administrative or judicial review. Although the statute requires that each hospital’s cost of uncompensated care as a percentage of the total uncompensated care cost of all DSH hospitals be used to allocate the pool, CMS previously determined that the available cost data from cost reports was unreliable and for FFYs 2014 through 2017 used low-income days (i.e., Medicaid days) to distribute UC DSH Amounts. Beginning in FFY 2018, CMS commenced a three-year transition to using uncompensated care cost data to distribute the UC DSH Amounts. As of December 31, 2018, 57 of our acute care hospitals in continuing operations, three of which were divested in January 2019, qualified for Medicare DSH payments.

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One of the variables used in the pre-ACA DSH formula is the number of Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Original Medicare Plan patients, but also Medicare Advantage patients in the SSI ratio. The statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates. We are unable to predict what action the Secretary might take with respect to the DSH calculation for prior periods in this regard or the outcome of the pending litigation; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement, which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of DGME and IME payments. As of December 31, 2018, 24 of our hospitals in continuing operations, three of which were divested in January 2019, were affiliated with academic institutions and were eligible to receive such payments.

IPPS Quality Adjustments—The ACA also authorizes the following quality adjustments to Medicare IPPS payments:

- Value Based Purchasing ("VBP") – Under the VBP program, IPPS operating payments to hospitals are reduced by 2% to fund value-based incentive payments to eligible hospitals based on their overall performance on a set of quality measures;
- Hospital Readmission Reduction Program ("HRRP") – Under the HRRP program, IPPS operating payments to hospitals with excess readmissions are reduced up to a maximum of 3% of base MS-DRG payments; and
- Hospital-Acquired Conditions ("HAC") Reduction Program ("HACRP") – Under the HACRP, overall inpatient payments are reduced by 1% for hospitals in the worst performing quartile of risk-adjusted quality measures for reasonable preventable HACs.

These adjustments are generally based on a hospital's performance from prior periods and are updated annually by CMS.

Hospital Outpatient Prospective Payment System

Under the outpatient prospective payment system, hospital outpatient services, except for certain services that are reimbursed on a separate fee schedule, are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are similar clinically and in terms of the resources they require, and a payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. CMS annually updates the APCs and the rates paid for each APC.

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility ("IPF") prospective payment system ("IPF-PPS") applies to psychiatric hospitals and psychiatric units located within acute care hospitals that have been designated as exempt from the hospital inpatient prospective payment system. The IPF-PPS is based on prospectively determined per-diem rates and includes an outlier policy that authorizes additional payments for extraordinarily costly cases. As of December 31, 2018, 23 of our

general hospitals in continuing operations, two of which were divested in January 2019, operated IPF units.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system. As of December 31, 2018, we operated one freestanding IRF, and 18 of our general hospitals in continuing operations, two of which were divested in January 2019, operated IRF units.

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Physician and Other Health Professional Services Payment System

Medicare uses a fee schedule to pay for physician and other health professional services based on a list of services and their payment rates referred to as the Medicare Physician Fee Schedule ("MPFS"). In determining payment rates for each service, CMS considers the amount of clinician work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are adjusted for variation in the input prices in different markets, and the sum is multiplied by the fee schedule's conversion factor (average payment amount) to produce a total payment amount. The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") established a new set of updates for clinicians billing under the MPFS that set the conversion factor.

Cost Reports

The final determination of certain Medicare payments to our hospitals, such as DSH, DGME, IME and bad debt expense, are retrospectively determined based on our hospitals' cost reports. The final determination of these payments often takes many years to resolve because of audits by the program representatives, providers' rights of appeal, and the application of numerous technical reimbursement provisions.

For filed cost reports, we adjust the accrual for estimated cost report settlements based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for estimated cost report settlements for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports and a corresponding valuation allowance is recorded as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Medicare Claims Reviews

HHS estimates that the overall FFY 2018 Medicare fee-for-service ("FFS") improper payment rate for the program is approximately 8.1%. The FFY 2018 error rate for Hospital IPPS payments is approximately 4.3%. CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. CMS has established several initiatives to prevent or identify improper payments before a claim is paid, and to identify and recover improper payments after paying a claim. The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types. Under the authority of the Act, CMS employs a variety of contractors (e.g., MACs, Recovery Audit Contractors and Unified Program Integrity Contractors) to process and review claims according to Medicare rules and regulations.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment and post-payment claims denials are subject to administrative and judicial review, and we intend to pursue the reversal of adverse determinations where appropriate. We have established robust protocols to respond to claims reviews and payment denials. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

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 19.8%, 20.4% and 20.3% of total net patient service revenues less implicit price concessions and provision for doubtful accounts of our acute care hospitals and related outpatient facilities for the years ended December 31, 2018, 2017 and 2016, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the years ended December 31, 2018, 2017 and 2016, our total Medicaid revenues attributable to DSH and other supplemental revenues were $847 million, $864 million and $906 million, respectively. The $847 million of total Medicaid revenues attributable to DSH and other supplemental revenues for the year ended December 31, 2018 was comprised of $262 million related to the California provider fee program described below, $286 million related to the Michigan provider fee program, $136 million related to Medicaid DSH programs in multiple states, $120 million related to the Texas 1115 waiver program described below, and $43 million from a number of other state and local programs.

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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.

The California Department of Health Care Services implemented its first Hospital Quality Assurance Fee ("HQAF") program in 2010. The HQAF program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. CMS approved the fifth and most recent phase of the program ("HQAF V") covering the period January 2017 through June 2019 in the three months ended December 31, 2017. Our hospitals recognized HQAF revenues, net of provider fees and other expenses, of $262 million, $267 million and $232 million in calendar years 2018, 2017 and 2016, respectively. In November 2016, California voters approved a state constitutional amendment measure that extends indefinitely the statute that imposes fees on hospitals to obtain federal matching funds. Because HQAF funding levels are based in part on Medi-Cal utilization, changes in coverage of individuals under the Medi-Cal program could affect the net revenues and cash flows of our hospitals under HQAF V and subsequent phases of the HQAF program. Also, because funding of the HQAF program is dependent on federal funding, we cannot provide assurances that such funding will continue in future periods.

Certain of our Texas hospitals participate in the Texas 1115 waiver program. The previous waiver term expired on December 31, 2017, and the current waiver extension ("Waiver"), which was approved during the three months ended December 31, 2017, covers the period January 1, 2018 through September 30, 2022. The Waiver is funded by intergovernmental transfer payments from local government entities, and includes two funding pools – Uncompensated Care and Delivery System Reform Payment. In 2018, we recognized $120 million of revenues from the Texas 1115 waiver program. Separately, during the same period, we incurred $78 million of expenses related to funding indigent care services by certain of our Texas hospitals. Under the terms of the Waiver, the amount of the funding pool for the period January 1, 2018 through September 30, 2019 is consistent with the latter years of the previous waiver; however, effective October 1, 2019, CMS requires that the funding pool be resized based on aggregate hospital charity cost. The final funding pool amount for the period October 1, 2019 through the end of the current Waiver term has not been determined. We are unable to predict the changes to the funding pool amount or the allocation of the funding pool amount, which could result in an increase or decrease to our net revenues and cash flows. Furthermore, we cannot provide any assurances as to future extensions of the Texas 1115 waiver program, or the ultimate amount of revenues that our hospitals may receive from this program following the expiration of the Waiver.

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 and Managed Medicaid net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations and other segment from Medicaid-related programs in the states in which our facilities are (or were, as the case may be) located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2018, 2017 and 2016 are set forth in the following table.

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	Years Ended December 31,		
Hospital Location	**2018**	**2017**	**2016**
Alabama	$91	$88	$80
Arizona	165	177	199
California	875	862	818
Florida	231	232	261
Georgia	—	(3)	19
Illinois	89	143	106
Massachusetts	94	83	89
Michigan	749	710	663
Missouri	—	2	2
North Carolina	—	(1)	(2)
Pennsylvania	8	285	279
South Carolina	53	46	50
Tennessee	35	36	39
Texas	398	371	466
	$2,788	**$3,031**	**$3,069**

Medicaid and Managed Medicaid revenues comprised 46% and 54%, respectively, of our Medicaid-related net patient service revenues from continuing operations recognized by the hospitals and related outpatient facilities in our Hospital Operations and other segment for the year ended December 31, 2018.

Regulatory and Legislative Changes

The Medicare and Medicaid programs are subject to statutory and regulatory changes, administrative and judicial rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid or services covered by governmental payers are reduced, or if we or one or more of our subsidiaries' hospitals are excluded from participation in the Medicare or Medicaid program or any other government healthcare program, there could be a material adverse effect on our business, financial condition, results of operations or cash flows. Recent regulatory and legislative updates to the Medicare and Medicaid payment systems are provided below.

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems. The updates generally become effective October 1, the beginning of the federal fiscal year. In August 2018, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2019 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.9% for 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 also made certain adjustments to the 2.9% market basket increase that result in a net operating payment update of 1.85% (before budget neutrality adjustments), including:

•

Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.8%, respectively; and

- A 0.5% increase required under the 21st Century Cures Act;

Updates to the three factors used to determine the amount and distribution of UC DSH Amounts, including the
- continuation of the transition from using low-income days to estimated uncompensated care costs for the distribution of the UC DSH Amounts;

- A 1.27% net increase in the capital federal MS-DRG rate;

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- A decrease in the cost outlier threshold from $26,537 to $25,769;

- The application of the Medicare IPPS post-acute transfer payment policy to "early discharges" from the hospital to hospice care as required by the Bipartisan Budget Act of 2018; and

- Effective January 1, 2019, the requirement that hospitals make available to the public a list of their current standard charges via the Internet in a machine-readable format and update this information at least annually or more often as appropriate.

According to CMS, the combined impact of the payment and policy changes in the Final IPPS Rule for operating costs will yield an average 2.4% increase in Medicare operating MS-DRG FFS payments for hospitals in large urban areas (populations over one million), and an average 2.1% increase in operating MS-DRG FFS payments for proprietary hospitals in FFY 2019. We estimate that all of the payment and policy changes affecting operating MS-DRG payments, including those affecting Medicare DSH amounts and the hospice transfer payment policy, will result in an estimated 1.9% increase in our annual Medicare FFS IPPS payments, which yields an estimated increase of approximately $35 million. Because of the uncertainty associated with various factors that may influence our future IPPS payments by individual hospital, including legislative or legal actions, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

Payment and Policy Changes to the Medicare Outpatient Prospective Payment and Ambulatory Surgery Center Payment Systems

On November 2, 2018, CMS released Changes to the Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year ("CY") 2019 ("Final OPPS/ASC Rule"). The Final OPPS/ASC Rule includes the following payment and policy changes:

- An estimated net increase of 1.35% for the OPPS rates based on an estimated market basket increase of 2.9% reduced by market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.8%, respectively;

- A transition over a two year period to the MPFS rates for the payment of clinic/office visits provided at off-campus, hospital-based departments that are currently paid under the OPPS (this payment reduction will not be made in a budget-neutral manner and will result in a reduction of approximately 0.6% to total CY 2019 OPPS payments);

- A 2.1% increase to the ASC payment rates; and

- A revision to the definition of "surgery" in the ASC payment system to account for certain "surgery-like" procedures, and the addition of 12 cardiac catheterization procedures and five related procedures to the ASC covered procedures list.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS/ASC Rule will yield an average 0.6% increase in Medicare FFS OPPS payments for all hospitals, an average 0.7% increase in Medicare FFS OPPS payments for hospitals in large urban areas (populations over one million), and an average 1.0% increase in Medicare FFS OPPS payments for proprietary hospitals. Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS/ASC Rule on our hospitals is an increase to Medicare FFS hospital outpatient revenues of approximately $7 million, which represents an increase of approximately 1.1%. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative or legal actions, volumes and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

The 340B program allows certain hospitals (i.e., only nonprofit organizations with specific federal designations and/or funding) to purchase separately-payable drugs at discounted rates from drug manufacturers. In the CY 2018 OPPS Final Rule, CMS reduced the payment for separately payable drugs purchased under the 340B program from average sale price ("ASP") plus 6% to ASP minus 22.5%, and made a corresponding budget-neutral increase to payments to all hospitals for other drugs and services reimbursed under the OPPS. During the three months ended December 31, 2018, the U.S. District Court for the District of Columbia held that the adoption of the 340B payment adjustment in the CY 2018 OPPS Final Rule exceeded CMS' statutory authority. Because of the complexity involved in determining equitable relief for the plaintiffs, the court requested the

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parties to submit briefs on the appropriate remedy. CMS may appeal the District Court's decision. The District Court's remedy and/or an unfavorable outcome of any appeal could have an adverse effect on the Company's net revenues and cash flows.

The Medicare Access and CHIP Reauthorization Act of 2015

The MACRA replaced the Medicare Sustainable Growth Rate methodology with a new system for establishing the annual updates to the MPFS that, beginning in 2019, rewards the delivery of high-quality patient care through one of two avenues:

- The Merit-Based Incentive Payment System ("MIPS") – MIPS participating providers will be eligible for a payment adjustment of plus or minus 4% in the first payment adjustment year (2019 based on 2017 performance) with the payment adjustment increasing each year until it reaches plus or minus 9% in 2022 and beyond; or
- The Advanced Alternative Payment Model ("APM") – Providers that choose to participate in an Advanced APM (defined as certain CMS Innovation Center models and Shared Savings Program tracks that require participants to use certified EHR technology, base payments for services on quality measures comparable to those in MIPS, and require participants to bear more than nominal financial risk for losses) will be exempt from MIPS and from 2019-2024 will be eligible for a 5% upward adjustment to their Medicare payments.

The new system helps to link fee-for-service payments to quality and value with payment incentives and penalties.

Additionally, the MACRA reduced the restoration of the 3.2% coding and document adjustment to hospital inpatient rates that was expected to be effective in FFY 2018 to 3.0%; as modified by the 21st Century Cures Act, the adjustment will be applied at the rate of 0.4588% for FFY 2018 and 0.5% for FFYs 2019 through 2023.

Less than 1% of the net operating revenue generated by our Hospital Operations and other segment during the year ended December 31, 2018 was related to the MPFS. We are unable to estimate the potential impact of the MACRA; however, the maximum incentive and penalty adjustments could result in an increase or decrease in our annual net revenues of approximately $15 million. Additionally, we cannot predict the effect of the MACRA on our future operations, revenues and cash flows.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On November 23, 2018, the CMS issued a final rule that includes updates to payment policies, payment rates, quality provisions and other policies for services furnished under the MPFS for CY 2019 ("MPFS Final Rule"). With the budget neutrality adjustment to account for changes in Relative Value Units required by law, the final MPFS for 2019 will increase by approximately 0.11%. CMS estimates that the impact of the payment and policy changes in the final rule will result in no change in aggregate payments across all specialties.

The American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 ("ARRA") was enacted to stimulate the U.S. economy. One provision of ARRA provides financial incentives to hospitals and physicians to become "meaningful users" of electronic health records ("EHR"). Hospitals that fail to demonstrate meaningful use of EHR are subject to payment penalties; EHR payment adjustments to physicians automatically terminated effective January 1, 2019. During the year ended December 31, 2018, we recognized $3 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of certain of our hospitals, employed physicians and Ambulatory Care segment facilities demonstrating meaningful use of certified EHR technology and meeting the criteria for revenue recognition.

Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Eligible hospitals must continue to demonstrate meaningful use of EHR technology every year to avoid payment reductions in subsequent years. These reductions, which are based on the market basket update, will continue until a hospital achieves compliance. Should all of our hospitals fail to become meaningful users or fail to continue to demonstrate meaningful use of EHR technology and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of up to approximately $37 million in 2019 and subsequent years.

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The complexity of the changes required to our hospitals' systems and the time required to complete the changes could result in some or all of our facilities not being fully compliant and subject to the payment penalties permitted under ARRA. Because of the uncertainties regarding the implementation of HIT, including CMS' future EHR implementation regulations, our ability to achieve compliance and the associated costs, we cannot provide any assurances regarding the aforementioned estimates of incentives or penalties in future periods.

CMS Innovation Models

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of Section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS. The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for communities and lower costs through improvement for our healthcare system. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria.

Bipartisan Budget Act of 2018

In February 2018, the President signed the Bipartisan Budget Act of 2018 ("2018 BBA"), a two-year spending agreement and six-week continuing resolution, into law. The 2018 BBA includes the following measures:

- Four additional years of CHIP funding through FFY 2027, as described above;
- Modifications to the MIPS under the MACRA;
- A reduction to the MPFS conversion factor for CY 2019 from 0.5% to 0.25%; and
- Modifications to the ACA Medicaid DSH payment reductions as follows:
  - elimination of the FFY 2018 and 2019 Medicaid DSH payment reductions;
  - retention of the $4 billion payment reduction in FFY 2020; and
  - an increase to the payment reductions in FFYs 2021 through 2025 to $8 billion.

The ACA reduced federal funding for Medicaid DSH payments under the assumption that hospital uncompensated care costs would decline as insurance coverage increased. Although the reductions were delayed several times, federal DSH payment reductions were slated to begin with a $2 billion reduction in FFY 2018, with additional reductions occurring each year through FFY 2025. The amount of federal DSH funds available to each state, referred to as allotments, will vary based on historical state DSH allotments and the methodology that CMS uses to distribute DSH allotment reductions among states. In notices dated November 3, 2017 and July 6, 2018, CMS released the preliminary DSH allotments of approximately $12 billion for FFYs 2017 and 2018, respectively.

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.

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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 service revenues, including Medicare and Medicaid managed care programs, from our hospitals and related outpatient facilities during the years ended December 31, 2018, 2017 and 2016 was $9.213 billion, $9.583 billion and $9.728 billion, respectively. Our top ten managed care payers generated 65% of our managed care net patient service revenues for the year ended December 31, 2018. National payers generated 43% of our managed care net patient service revenues for the year ended December 31, 2018. The remainder comes from regional or local payers. At December 31, 2018 and 2017, 61% and 62%, respectively, 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/or other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. 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 December 31, 2018, 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 and payment levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. We believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our revenues. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans. Managed care accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for these payers and other factors that affect the estimation process.

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 benefited from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate in recent years, and we believe the moderation could continue in future years. In the year ended December 31, 2018, our commercial managed care net inpatient revenue per admission from the hospitals and related outpatient facilities in our Hospital Operations and other segment was approximately 89% 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.

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant number of

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our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts.

Self-pay accounts pose significant collectability problems. At both December 31, 2018 and 2017, 6% of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our implicit price concessions relates to self-pay patients, as well as co-pays, co-insurance amounts and deductibles owed to us by patients with insurance. We provide revenue cycle management services through Conifer, which is subject to various statutes and regulations regarding consumer protection in areas including finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of this report.

Conifer has performed systematic analyses to focus our attention on the drivers of bad debt expense for each hospital. While emergency department use is the primary contributor to our implicit price concessions in the aggregate, this is not the case at all hospitals. As a result, we have increased our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay, co-insurance and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We leverage a statistical-based collections model that aligns our operational capacity to maximize our collections performance. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

Over the longer term, several other initiatives we have previously announced should also help address this challenge. For example, our *Compact with Uninsured Patients* ("*Compact*") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically had been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the *Compact*, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through implicit price concessions based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The following table shows our estimated costs (based on selected operating expenses) of caring for self-pay patients and charity care patients, as well as revenues attributable to Medicaid DSH and other supplemental revenues we recognized, in the years ended December 31, 2018, 2017 and 2016.

	Years Ended December 31,		
	2018	2017	2016

Estimated costs for:			
Self-pay patients	$640	$648	$609
Charity care patients	124	121	138
Total	$764	$769	$747
Medicaid DSH and other supplemental revenues	$847	$864	$906

The initial expansion of health insurance coverage resulted in an increase in the number of patients using our facilities with either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage and for persons living in the country who are not permitted to enroll in a health insurance exchange or government healthcare insurance program. In October 2017, the administration announced that reimbursements to insurance companies for ACA cost-sharing reduction ("CSR") plans offered through the health insurance marketplace would be discontinued. CSR payments compensate insurers

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for subsidizing out-of-pocket costs for low-income enrollees. Without the CSR payments, many insurers increased premiums for plans offered on ACA exchanges and a few withdrew entirely from offering plans on some of the exchanges.

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2018 COMPARED TO THE YEAR ENDED DECEMBER 31, 2017

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2018 and 2017:

	Years Ended December 31,		
	2018	2017	Increase (Decrease)
Net operating revenues:			
Hospital Operations and other	$15,285	$17,656	$(2,371)
Ambulatory Care	2,085	1,978	107
Conifer	1,533	1,597	(64)
Inter-segment eliminations	(590)	(618)	28
Net operating revenues before provision for doubtful accounts	18,313	20,613	(2,300)
Less provision for doubtful accounts	—	1,434	(1,434)
Net operating revenues	**18,313**	**19,179**	**(866)**
Equity in earnings of unconsolidated affiliates	**150**	**144**	**6**
Operating expenses:			
Salaries, wages and benefits	8,634	9,274	(640)
Supplies	3,004	3,085	(81)
Other operating expenses, net	4,259	4,570	(311)
Electronic health record incentives	(3)	(9)	6
Depreciation and amortization	802	870	(68)
Impairment and restructuring charges, and acquisition-related costs	209	541	(332)
Litigation and investigation costs	38	23	15
Net gains on sales, consolidation and deconsolidation of facilities	(127)	(144)	17
Operating income	**$1,647**	**$1,113**	**$534**

	Years Ended December 31,		
	2018	2017	Increase (Decrease)
Net operating revenues	100.0 %	100.0 %	— %
Equity in earnings of unconsolidated affiliates	0.8 %	0.8 %	— %
Operating expenses:			
Salaries, wages and benefits	47.1 %	48.4 %	(1.3)%
Supplies	16.4 %	16.1 %	0.3 %
Other operating expenses, net	23.3 %	23.8 %	(0.5)%
Electronic health record incentives	— %	— %	— %
Depreciation and amortization	4.4 %	4.5 %	(0.1)%
Impairment and restructuring charges, and acquisition-related costs	1.1 %	2.8 %	(1.7)%
Litigation and investigation costs	0.2 %	0.1 %	0.1 %
Net gains on sales, consolidation and deconsolidation of facilities			