TENET HEALTHCARE CORP
Form 10-Q
August 07, 2017

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Form 10-Q

Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the quarterly period ended June 30, 2017

OR

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

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION
(Exact name of Registrant as specified in its charter)

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

1445 Ross Avenue, Suite 1400
Dallas, TX 75202
(Address of principal executive offices, including zip code)

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

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

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

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

At July 31, 2017, there were 100,820,539 shares of the Registrant’s common stock, $0.05 par value, outstanding.

Table of Contents

TENET HEALTHCARE CORPORATION
TABLE OF CONTENTS

Table of Contents

PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
Dollars in Millions
(Unaudited)

	June 30, 2017	December 31, 2016
ASSETS		
Current assets:		
Cash and cash equivalents	$475	$716
Accounts receivable, less allowance for doubtful accounts ($966 at June 30, 2017 and $1,031 at December 31, 2016)	2,706	2,897
Inventories of supplies, at cost	316	326
Income tax receivable	7	4
Assets held for sale	705	29
Other current assets	1,173	1,285
Total current assets	5,382	5,257
Investments and other assets	1,238	1,250
Deferred income taxes	1,020	871
Property and equipment, at cost, less accumulated depreciation and amortization ($4,826 at June 30, 2017 and $4,974 at December 31, 2016)	7,738	8,053
Goodwill	7,157	7,425
Other intangible assets, at cost, less accumulated amortization ($839 at June 30, 2017 and $772 at December 31, 2016)	1,806	1,845
Total assets	$24,341	$24,701
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$143	$191
Accounts payable	1,086	1,329
Accrued compensation and benefits	749	872
Professional and general liability reserves	208	181
Accrued interest payable	238	210
Liabilities held for sale	51	9
Accrued legal settlement costs	1	8
Other current liabilities	1,861	1,234
Total current liabilities	4,337	4,034
Long-term debt, net of current portion	15,012	15,064
Professional and general liability reserves	644	613
Defined benefit plan obligations	618	626
Deferred income taxes	296	279
Other long-term liabilities	598	610
Total liabilities	21,505	21,226
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	1,781	2,393
Equity:		
Shareholders’ equity:		

Common stock, $0.05 par value; authorized 262,500,000 shares; 149,127,794 shares issued at June 30, 2017 and 148,106,249 shares issued at December 31, 2016	7	7
Additional paid-in capital	4,819	4,827
Accumulated other comprehensive loss	(242)	(258)
Accumulated deficit	(1,794)	(1,742)
Common stock in treasury, at cost, 48,417,575 shares at June 30, 2017 and 48,420,650 shares at December 31, 2016	(2,417)	(2,417)
Total shareholders' equity	373	417
Noncontrolling interests	682	665
Total equity	1,055	1,082
Total liabilities and equity	$24,341	$24,701

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Net operating revenues:				
Net operating revenues before provision for doubtful accounts	$5,173	$5,220	$10,369	$10,640
Less: Provision for doubtful accounts	371	352	754	728
Net operating revenues	4,802	4,868	9,615	9,912
Equity in earnings of unconsolidated affiliates	28	30	57	54
Operating expenses:				
Salaries, wages and benefits	2,346	2,309	4,726	4,704
Supplies	780	773	1,545	1,584
Other operating expenses, net	1,159	1,213	2,346	2,455
Electronic health record incentives	(6)	(21)	(7)	(21)
Depreciation and amortization	222	215	443	427
Impairment and restructuring charges, and acquisition-related costs	41	22	74	50
Litigation and investigation costs	1	114	6	287
Gains on sales, consolidation and deconsolidation of facilities	(23)	(1)	(38)	(148)
Operating income	310	274	577	628
Interest expense	(260)	(244)	(518)	(487)
Other non-operating expense, net	(5)	(5)	(10)	(11)
Loss from early extinguishment of debt	(26)	—	(26)	—
Net income from continuing operations, before income taxes	19	25	23	130
Income tax benefit (expense)	12	16	45	(51)
Net income from continuing operations, before discontinued operations	31	41	68	79
Discontinued operations:				
Income (loss) from operations	2	(2)	—	(7)
Income tax benefit (expense)	(1)	—	—	1
Net income (loss) from discontinued operations	1	(2)	—	(6)
Net income	32	39	68	73
Less: Net income attributable to noncontrolling interests	87	85	176	178
Net loss attributable to Tenet Healthcare Corporation common shareholders	$(55)	$(46)	$(108)	$(105)
Amounts attributable to Tenet Healthcare Corporation common shareholders				
Net loss from continuing operations, net of tax	$(56)	$(44)	$(108)	$(99)
Net income (loss) from discontinued operations, net of tax	1	(2)	—	(6)
Net loss attributable to Tenet Healthcare Corporation common shareholders	$(55)	$(46)	$(108)	$(105)
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:				
Basic				
Continuing operations	$(0.56)	$(0.44)	$(1.08)	$(1.00)
Discontinued operations	0.01	(0.02)	—	(0.06)
	$(0.55)	$(0.46)	$(1.08)	$(1.06)
Diluted				
Continuing operations	$(0.56)	$(0.44)	$(1.08)	$(1.00)

Discontinued operations	0.01	(0.02)	—	(0.06)
	$(0.55)	$(0.46)	$(1.08)	$(1.06)
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	100,612	99,341	100,306	99,054
Diluted	100,612	99,341	100,306	99,054

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME (LOSS)
Dollars in Millions
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Net income	$32	$39	$68	$73
Other comprehensive income:				
Amortization of net actuarial loss included in other non-operating expense, net	4	3	8	3
Unrealized gains (losses) on securities held as available-for-sale	1	(2)	3	1
Foreign currency translation adjustments	6	(43)	9	(41)
Other comprehensive income (loss) before income taxes	11	(42)	20	(37)
Income tax benefit (expense) related to items of other comprehensive income (loss)	2	(1)	(4)	(2)
Total other comprehensive income (loss), net of tax	13	(43)	16	(39)
Comprehensive net income (loss)	45	(4)	84	34
Less: Comprehensive income attributable to noncontrolling interests	87	85	176	178
Comprehensive loss attributable to Tenet Healthcare Corporation common shareholders	$(42)	$(89)	$(92)	$(144)

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions
(Unaudited)

	Six Months Ended June 30,	
	2017	2016
Net income	$68	$73
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	443	427
Provision for doubtful accounts	754	728
Deferred income tax expense (benefit)	(81)	37
Stock-based compensation expense	29	35
Impairment and restructuring charges, and acquisition-related costs	74	50
Litigation and investigation costs	6	287
Gains on sales, consolidation and deconsolidation of facilities	(38)	(148)
Loss from early extinguishment of debt	26	—
Equity in earnings of unconsolidated affiliates, net of distributions received	4	10
Amortization of debt discount and debt issuance costs	22	21
Pre-tax loss from discontinued operations	—	7
Other items, net	(25)	(2)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(673)	(725)
Inventories and other current assets	160	(30)
Income taxes	(7)	(17)
Accounts payable, accrued expenses and other current liabilities	(345)	(106)
Other long-term liabilities	48	34
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	(62)	(99)
Net cash used in operating activities from discontinued operations, excluding income taxes	(2)	—
Net cash provided by operating activities	401	582
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(348)	(413)
Purchases of businesses or joint venture interests, net of cash acquired	(26)	(94)
Proceeds from sales of facilities and other assets	74	573
Proceeds from sales of marketable securities, long-term investments and other assets	16	24
Purchases of equity investments	(2)	(35)
Other long-term assets	(12)	(3)
Other items, net	(10)	2
Net cash provided by (used in) investing activities	(308)	54
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(100)	(1,195)
Proceeds from borrowings under credit facility	100	1,195
Repayments of other borrowings	(1,029)	(76)
Proceeds from other borrowings	837	—
Debt issuance costs	(29)	—
Distributions paid to noncontrolling interests	(123)	(95)
Proceeds from sales of noncontrolling interests	14	15
Purchases of noncontrolling interests	(5)	(177)

Proceeds from employee stock plan purchases	3	3
Other items, net	(2)	(6)
Net cash used in financing activities	(334)	(336)
Net increase (decrease) in cash and cash equivalents	(241)	300
Cash and cash equivalents at beginning of period	716	356
Cash and cash equivalents at end of period	$475	$656
Supplemental disclosures:		
Interest paid, net of capitalized interest	$(468)	$(467)
Income tax payments, net	$(44)	$(29)

See accompanying Notes to Condensed Consolidated Financial Statements.

Table of Contents

TENET HEALTHCARE CORPORATION
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. At June 30, 2017, we operated 80 hospitals, 20 short-stay surgical hospitals and over 470 outpatient centers in the United States, as well as nine facilities in the United Kingdom, through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI joint venture"). 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.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2016 ("Annual Report"). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). In addition to the impact of the new accounting standards discussed below, certain prior-year amounts have also been reclassified to conform to the current-year presentation, primarily related to the detail of other intangible assets in Note 1 and the line items presented in the changes in shareholders' equity table in Note 8.

Effective January 1, 2017, we adopted the Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2016-09, "Compensation—Stock Compensation (Topic 718) Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-09"), which affects all entities that issue share-based payment awards to their employees. The guidance in ASU 2016-09 simplifies several aspects of the accounting for share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. Upon adoption of ASU 2016-09, we recorded previously unrecognized excess tax benefits of approximately $56 million as a deferred tax asset and a cumulative effect adjustment to retained earnings as of January 1, 2017. Prospectively, all excess tax benefits and deficiencies will be recognized as income tax benefit or expense in our consolidated statement of operations when awards vest.

Also effective January 1, 2017, we early adopted ASU 2017-07, "Compensation—Retirement Benefits (Topic 715) Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost" ("ASU 2017-07"), which the FASB issued in March 2017. The amendments in ASU 2017-07 apply to all employers that offer to their employees defined benefit pension plans, other postretirement benefit plans, or other types of benefits accounted for under Topic 715 of the FASB Accounting Standards Codification. The guidance in ASU 2017-07 requires that an employer report the service cost component in the same line item or items as other compensation costs arising from services rendered by the pertinent employees during the period. The other components of net benefit cost are required to be presented in the statement of operations separately from the service cost component and outside a subtotal of income from operations. The line item or items used in the statement of operations to present the other components of net benefit cost must be disclosed. The amendments in ASU 2017-07 must be applied retrospectively for the presentation of the service cost component and the other components of net periodic pension cost and net periodic postretirement benefit cost in the statement of operations. As a result of the adoption of ASU 2017-07, we reclassified approximately $14 million of net benefit cost from salaries, wages and benefits expense to other non-operating income (expense), net, in the accompanying Condensed Consolidated Statement of Operations for both

of the six month periods ended June 30, 2017 and 2016. Upon adoption of ASU 2017-07, we also reclassified approximately $6 million and $8 million of net benefit cost from salaries, wages and benefits expense to other non-operating income (expense), net for the three month periods ended September 30, 2016 and December 31, 2016, respectively, and we reclassified approximately $21 million of net benefit cost from salaries, wages and benefits expense to other non-operating income (expense), net for the year ended December 31, 2015.

Although the Condensed Consolidated Financial Statements and related notes within this document are unaudited, we believe all adjustments considered necessary for a fair presentation have been included and are of a normal recurring nature. In preparing our financial statements in conformity with accounting principles generally accepted in the United States of America (“GAAP”), we are required to make estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular

Table of Contents

circumstances in which we operate. Actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Operating results for the three and six month periods ended June 30, 2017 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; 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 or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

Translation of Foreign Currencies

The accounts of European Surgical Partners Limited (“Aspen”) were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities were translated using the current rate of exchange at the balance sheet date. Results of operations were translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates are accumulated in shareholders’ equity. Deferred U.S. taxes have not been provided with respect to translation gains or losses because Aspen’s accumulated earnings are indefinitely reinvested outside the United States.

Net Operating Revenues Before Provision for Doubtful Accounts

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

6

Table of Contents

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Hospital Operations and other:				
Net patient revenues from acute care hospitals, related outpatient facilities and physician practices				
Medicare	$852	$915	$1,754	$1,814
Medicaid	291	296	566	670
Managed care	2,664	2,539	5,343	5,302
Indemnity, self-pay and other	449	484	874	936
Net patient revenues(1)	4,256	4,234	8,537	8,722
Health plans	25	136	90	263
Revenue from other sources	164	174	309	324
Hospital Operations and other total prior to inter-segment eliminations	4,445	4,544	8,936	9,309
Ambulatory Care	483	452	945	889
Conifer	400	386	802	771
Inter-segment eliminations	(155)	(162)	(314)	(329)
Net operating revenues before provision for doubtful accounts	$5,173	$5,220	$10,369	$10,640

(1) Net patient revenues include revenues from physician practices of $190 million and $186 million for the three months ended June 30, 2017 and 2016, respectively, and $380 million and $379 million for the six months ended June 30, 2017 and 2016, respectively.

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $475 million and $716 million at June 30, 2017 and December 31, 2016, respectively. At June 30, 2017 and December 31, 2016, our book overdrafts were approximately $187 million and $279 million, respectively, which were classified as accounts payable.

At June 30, 2017 and December 31, 2016, approximately $160 million and $147 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries, and approximately $84 million and $85 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our health plan-related businesses.

Also at June 30, 2017 and December 31, 2016, we had $92 million and $179 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $57 million and $141 million, respectively, were included in accounts payable.

During the six months ended June 30, 2017 and 2016, we entered into non-cancellable capital leases of approximately $43 million and $77 million, respectively, primarily for equipment.

Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets at June 30, 2017 and December 31, 2016:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At June 30, 2017:			
Capitalized software costs	$ 1,581	$ (728)	$ 853
Trade names	106	—	106
Contracts	849	(51)	798
Other	109	(60)	49
Total	$ 2,645	$ (839)	$ 1,806

Table of Contents

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2016:			
Capitalized software costs	$ 1,572	$ (681)	$891
Trade names	106	—	106
Contracts	845	(43)	802
Other	94	(48)	46
Total	$ 2,617	$ (772)	$1,845

Estimated future amortization of intangibles with finite useful lives at June 30, 2017 is as follows:

	Total	Six Months Ending December 31, 2017	Years Ending 2018	2019	2020	2021	Later Years
Amortization of intangible assets	$1,146	$90	$152	$132	$101	$ 89	$582

We recognized amortization expense of $81 million and $78 million in the accompanying Condensed Consolidated Statements of Operations for the six months ended June 30, 2017 and 2016, respectively.

Investments in Unconsolidated Affiliates

We control 219 of the facilities within our Ambulatory Care segment and, therefore, consolidate their results. We account for many of the facilities our Ambulatory Care segment operates (107 of 326 at June 30, 2017) and four of the hospitals our Hospital Operations and other segment operates, as well as 11 additional facilities in which our Hospital Operations and other segment holds ownership interests, under the equity method as investments in unconsolidated affiliates and report only our share of net income attributable to the investee as equity in earnings of unconsolidated affiliates in the accompanying Condensed Consolidated Statements of Operations. Summarized financial information for the equity method investees within our Ambulatory Care segment and the four equity method investee hospitals operated by our Hospital Operations and other segment are included in the following table. For investments acquired during the reported periods, amounts reflect 100% of the investee's results beginning on the date of our acquisition of the investment.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Net operating revenues	$600	$615	$1,184	$1,193
Net income	$118	$130	$233	$235
Net income attributable to the investees	$73	$89	$149	$158

NOTE 2. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

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

	June 30, 2017	December 31, 2016
Continuing operations:		
Patient accounts receivable	$3,558	$ 3,799
Allowance for doubtful accounts	(966)	(1,031)

Estimated future recoveries	129	141
Net cost reports and settlements payable and valuation allowances	(17)	(14)
	2,704	2,895
Discontinued operations	2	2
Accounts receivable, net	$2,706	$ 2,897

At June 30, 2017 and December 31, 2016, our allowance for doubtful accounts was 27.2% and 27.1%, respectively, of our patient accounts receivable. Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors.

Table of Contents

We also provide charity care to patients who are unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. The table below shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses and which exclude the costs of our health plan businesses) of caring for our self-pay patients and charity care patients, and revenues attributable to Medicaid DSH and other supplemental revenues we recognized in three and six months ended June 30, 2017 and 2016:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Estimated costs for:				
Self-pay patients	$160	$151	$320	$295
Charity care patients	33	29	63	68
Total	$193	$180	$383	$363
Medicaid DSH and other supplemental revenues	$164	$215	$322	$442

At June 30, 2017 and December 31, 2016, we had approximately $380 million and $537 million, respectively, of receivables recorded in other current assets and approximately $97 million and $139 million, respectively, of payables recorded in other current liabilities in the accompanying Condensed Consolidated Balance Sheets related to California's provider fee program.

NOTE 3. ASSETS AND LIABILITIES HELD FOR SALE

In the three months ended June 30, 2017, we entered into a definitive agreement for the sale of our hospitals, physician practices and related assets in Houston, Texas and the surrounding area. In accordance with the guidance in the FASB's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," we classified $705 million of our Houston-area assets as "assets held for sale" in current assets and the related liabilities of $51 million as "liabilities held for sale" in current liabilities in the accompanying Condensed Consolidated Balance Sheet at June 30, 2017. These assets and liabilities were recorded at the lower of their carrying amount or their fair value less estimated costs to sell. There was no impairment recorded for the write-down of assets held for sale to their estimated fair value, less estimated costs to sell, as a result of this anticipated transaction.

Assets and liabilities classified as held for sale at June 30, 2017, all of which were in the Hospital Operations and other segment, were comprised of the following:

Accounts receivable	$113
Other current assets	25
Investments and other long-term assets	3
Property and equipment	217
Other intangible assets	37
Goodwill	310
Current liabilities	(48)
Long-term liabilities	(3)
Net assets held for sale	$654

In the three months ended September 30, 2016, certain of our health plan assets and liabilities met the criteria to be classified as held for sale. In the three months ended March 31, 2017, we completed the sale of our health plan businesses in Michigan at a transaction price of approximately $16 million and recognized a gain on sale of approximately $9 million. In the three months ended June 30, 2017, we completed the sales of certain of our health plan businesses in Arizona and Texas at transaction prices of approximately $13 million and $12 million, respectively, and recognized gains on the sales of approximately $13 million and $10 million, respectively.

Our hospitals, physician practices and related assets in Georgia met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. We completed the sale of our Georgia assets on March 31, 2016 at a transaction price of approximately $575 million and recognized a gain on sale of approximately $113 million. Because we did not sell the related accounts receivable with respect to the pre-closing period, net receivables of approximately $25 million are included in

Table of Contents

accounts receivable, less allowance for doubtful accounts, in the accompanying Condensed Consolidated Balance Sheet at June 30, 2017.

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

During the six months ended June 30, 2017, we recorded impairment and restructuring charges and acquisition-related costs of $74 million primarily related to our Hospital Operations and other segment, consisting of an approximately $15 million impairment of two equity method investments, $30 million of employee severance costs, $7 million of contract and lease termination fees, $2 million to write-down intangible assets, $7 million of other restructuring costs, and $13 million in acquisition-related costs, which include $2 million of transaction costs and $11 million of acquisition integration charges.

During the six months ended June 30, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $50 million primarily related to our Hospital Operations and other segment, consisting of approximately $17 million of employee severance costs, $1 million of contract and lease termination fees, $2 million to write-down intangible assets, $2 million of other restructuring costs, and $28 million in acquisition-related costs, which include $3 million of transaction costs and $25 million of acquisition integration charges.

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

At June 30, 2017, our continuing operations consisted of three reportable segments, Hospital Operations and other, Ambulatory Care and Conifer. Our Hospital Operations and other segment was structured as follows at June 30, 2017:

- Our Eastern region included all of our segment operations in Alabama, Florida, Illinois, Massachusetts, Michigan, Missouri, Pennsylvania, South Carolina and Tennessee;
- Our Texas region included all of our segment operations in New Mexico and Texas; and
- Our Western region included all of our segment operations in Arizona and California.

These regions are reporting units used to perform our goodwill impairment analysis and are one level below our reportable business segments. We also perform a goodwill impairment analysis for our Ambulatory Care and Conifer reporting units.

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

Table of Contents

NOTE 5. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt at June 30, 2017 and December 31, 2016:

	June 30, 2017	December 31, 2016
Senior unsecured notes:		
5.000% due 2019	$1,100	$ 1,100
5.500% due 2019	500	500
6.750% due 2020	300	300
8.000% due 2020	750	750
8.125% due 2022	2,800	2,800
6.750% due 2023	1,900	1,900
6.875% due 2031	430	430
Senior secured notes:		
6.250% due 2018	1,041	1,041
4.750% due 2020	500	500
6.000% due 2020	1,800	1,800
Floating % due 2020	—	900
4.500% due 2021	850	850
4.375% due 2021	1,050	1,050
7.500% due 2022	750	750
4.625% due 2024	830	—
Capital leases	684	735
Mortgage notes	81	84
Unamortized issue costs, note discounts and premiums	(211)	(235)
Total long-term debt	15,155	15,255
Less current portion	143	191
Long-term debt, net of current portion	$15,012	$ 15,064

Senior Secured Notes

On June 14, 2017, we sold $830 million aggregate principal amount of our 4.625% senior secured first lien notes, which will mature on July 15, 2024 (the “2024 Secured First Lien Notes”). We will pay interest on the 2024 Secured First Lien Notes semi-annually in arrears on January 15 and July 15 of each year, commencing on January 15, 2018. The proceeds from the sale of the 2024 Secured First Lien Notes were used, after payment of fees and expenses, together with cash on hand, to deposit with the trustee an amount sufficient to fund the redemption of all $900 million in aggregate principal amount of our floating rate senior secured notes due 2020 (the “2020 Floating Rate Notes”) on July 14, 2017, thereby fully discharging the 2020 Floating Rate Notes as of June 14, 2017. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $26 million, primarily related to the difference between the redemption price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs. Several other debt refinancing transactions were completed in July and August 2017, as further described in Note 18.

Credit Agreement

We have a senior secured revolving credit facility (as amended, the “Credit Agreement”) that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Obligations under the Credit Agreement, which has a scheduled maturity date of December 4, 2020, are guaranteed by substantially all of our domestic wholly owned hospital subsidiaries and are

secured by a first-priority lien on the accounts receivable owned by us and the subsidiary guarantors. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 0.25% to 0.75% per annum or the London Interbank Offered Rate ("LIBOR") plus a margin ranging from 1.25% to 1.75% per annum, in each case based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.25% to 0.375% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At June 30, 2017, we had no cash borrowings outstanding under the Credit Agreement, and we had approximately $2 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $998 million was available for borrowing under the Credit Agreement at June 30, 2017.

Table of Contents

Letter of Credit Facility

We have a letter of credit facility (as amended, the "LC Facility") that provides for the issuance of standby and documentary letters of credit, from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). Obligations under the LC Facility are guaranteed and secured by a first-priority pledge of the capital stock and other ownership interests of certain of our wholly owned domestic hospital subsidiaries on an equal ranking basis with our senior secured first lien notes. On September 15, 2016, we entered into an amendment to the existing letter of credit facility agreement in order to, among other things, (i) extend the scheduled maturity date of the LC Facility to March 7, 2021, (ii) reduce the margin payable with respect to unreimbursed drawings under letters of credit and undrawn letters of credit issued under the LC Facility, and (iii) reduce the commitment fee payable with respect to the undrawn portion of the commitments under the LC Facility.

Drawings under any letter of credit issued under the LC Facility that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.50% per annum. An unused commitment fee is payable at an initial rate of 0.25% per annum with a step up to 0.375% per annum should our secured-debt-to-EBITDA ratio equal or exceed 3.00 to 1.00 at the end of any fiscal quarter. A fee on the aggregate outstanding amount of issued but undrawn letters of credit will accrue at a rate of 1.50% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At June 30, 2017, we had approximately $108 million of standby letters of credit outstanding under the LC Facility.

NOTE 6. GUARANTEES

At June 30, 2017, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $123 million. We had a total liability of $96 million recorded for these guarantees included in other current liabilities at June 30, 2017.

At June 30, 2017, we also had issued guarantees of the indebtedness and other obligations of our investees to third parties, the maximum potential amount of future payments under which was approximately $28 million. Of the total, $17 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Condensed Consolidated Balance Sheet at June 30, 2017.

NOTE 7. EMPLOYEE BENEFIT PLANS

In recent years, we have granted both options and restricted stock units to certain of our employees. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Typically, options and time-based restricted stock units vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have longer vesting periods. In addition, we grant performance-based restricted stock units and performance-based options that vest subject to the achievement of specified performance goals within a specified time frame. At June 30, 2017, assuming outstanding performance-based restricted stock units and options for which performance has not yet been determined will achieve target performance, approximately 5.9 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units (approximately 4.9 million shares remain available if we assume maximum performance for outstanding performance-based restricted stock units and options for which performance has not yet been determined).

Our Condensed Consolidated Statements of Operations for the six months ended June 30, 2017 and 2016 include $29 million and $31 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements.

Table of Contents

Stock Options

The following table summarizes stock option activity during the six months ended June 30, 2017:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value	Weighted Average Remaining Life
			(In Millions)	
Outstanding at December 31, 2016	1,435,921	$ 22.87		
Granted	987,781	18.99		
Exercised	(11,175)	4.56		
Forfeited/Expired	(187,458)	26.07		
Outstanding at June 30, 2017	2,225,069	$ 20.97	$ 3	5.4 years
Vested and expected to vest at June 30, 2017	2,225,069	$ 20.97	$ 3	5.4 years
Exercisable at June 30, 2017	1,237,288	$ 22.55	$ 2	1.9 years

There were 11,175 and 104,815 stock options exercised during the six months ended June 30, 2017 and 2016, respectively, with aggregate intrinsic values of less than $1 million and approximately $1 million, respectively.

At June 30, 2017, there were $7 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 2.7 years.

In the six months ended June 30, 2017, we granted an aggregate of 987,781 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. The stock options will all vest on the third anniversary of the grant date, subject to achieving a closing stock price of at least $23.74 (a 25% premium above the March 1, 2017 grant-date closing stock price of $18.99) for at least 20 consecutive trading days within three years of the grant date, and will expire on the tenth anniversary of the grant date. In the six months ended June 30, 2016, there were no stock options granted.

The weighted average estimated fair value of stock options we granted in the six months ended June 30, 2017 was $8.52 per share. The fair values were calculated based on the grant date, using a Monte Carlo simulation with the following assumptions:

	Six Months Ended June 30, 2017
Expected volatility	49%
Expected dividend yield	0%
Expected life	6.2 years
Expected forfeiture rate	0%
Risk-free interest rate	2.15%

The expected volatility used in the Monte Carlo simulation incorporates historical and implied share-price volatility and is based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price on two dates (April 8, 2011 and April 11, 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from Tenet’s historical stock option exercise behavior, adjusted for the exercisable period (i.e., from the third anniversary through the tenth anniversary of the grant date). The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise time frames.

13

Table of Contents

The following table summarizes information about our outstanding stock options at June 30, 2017:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	159,711	1.7 years	$ 4.56	159,711	$ 4.56
$4.57 to $19.759	988,081	9.7 years	18.99	300	14.52
$19.76 to $32.569	822,890	2.3 years	20.87	822,890	20.87
$32.57 to $42.529	254,387	0.7 years	39.31	254,387	39.31
	2,225,069	5.4 years	$ 20.97	1,237,288	$ 22.55

Restricted Stock Units

The following table summarizes restricted stock unit activity during the six months ended June 30, 2017:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2016	3,174,533	$ 38.75
Granted	614,208	18.72
Vested	(1,291,475)	35.95
Forfeited	(52,135)	36.64
Unvested at June 30, 2017	2,445,131	$ 35.46

In the six months ended June 30, 2017, we granted 614,208 restricted stock units, of which 601,305 will vest and be settled ratably over a three-year period from the grant date. The vesting of the remaining 12,903 restricted stock units is contingent on our achievement of specified performance goals for the years 2017 to 2019. Provided the goals are achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 12,903 units granted, depending on our level of achievement with respect to the performance goals.

At June 30, 2017, there were $55 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 1.9 years.

Employee Retirement Plans

In both of the six-month periods ended June 30, 2017 and 2016, we recognized (i) service cost related to one of our frozen nonqualified defined benefit pension plans of approximately $1 million in salaries, wages and benefits expense, and (ii) other components of net periodic pension cost and net periodic postretirement benefit cost related to our frozen qualified and nonqualified defined benefit plans of approximately $14 million in other non-operating income (expense), net, in the accompanying Condensed Consolidated Statements of Operations.

Table of Contents

NOTE 8. EQUITY

Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the six months ended June 30, 2017 and 2016 (dollars in millions, share amounts in thousands):

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balances at December 31, 2016	99,686	$ 7	$ 4,827	$ (258)	$ (1,742)	$ (2,417)	$ 665	$ 1,082
Net income (loss)	—	—	—	—	(108)	—	71	(37)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(65)	(65)
Other comprehensive income	—	—	—	16	—	—	—	16
Accretion of redeemable noncontrolling interests	—	—	(29)	—	—	—	—	(29)
Purchases (sales) of businesses and noncontrolling interests	—	—	(4)	—	—	—	11	7
Cumulative effect of accounting change	—	—	—	—	56	—	—	56
Stock-based compensation expense, tax benefit and issuance of common stock	1,024	—	25	—	—	—	—	25
Balances at June 30, 2017	100,710	$ 7	$ 4,819	$ (242)	$ (1,794)	$ (2,417)	$ 682	$ 1,055
Balances at December 31, 2015	98,495	$ 7	$ 4,815	$ (164)	$ (1,550)	$ (2,417)	$ 267	$ 958
Net income (loss)	—	—	—	—	(105)	—	62	(43)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(51)	(51)
Other comprehensive loss	—	—	—	(39)	—	—	—	(39)
Purchases (sales) of businesses and noncontrolling interests	—	—	(36)	—	—	—	114	78
Purchase accounting adjustments	—	—	—	—	—	—	237	237
Stock-based compensation expense and issuance of common stock	1,021	—	12	—	—	—	—	12
Balances at June 30, 2016	99,516	$ 7	$ 4,791	$ (203)	$ (1,655)	$ (2,417)	$ 629	$ 1,152

Our noncontrolling interests balances at June 30, 2017 and December 31, 2016 were comprised of $91 million and $89 million, respectively, from our Hospital Operations and other segment, and $591 million and $576 million, respectively, from our Ambulatory Care segment. Our net income attributable to noncontrolling interests for the six months ended June 30, 2017 and 2016 in the table above were comprised of $9 million and $5 million, respectively, from our Hospital Operations and other segment, and $62 million and $57 million, respectively, from our Ambulatory Care segment.

NOTE 9. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy period April 1, 2017 through March 31, 2018, 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 and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Other covered losses, including floods, fires and other perils, have a minimum deductible of $1 million.

Table of Contents

Professional and General Liability Reserves

At June 30, 2017 and December 31, 2016, the aggregate current and long-term professional and general liability reserves in our accompanying Condensed Consolidated Balance Sheets were approximately $852 million and $794 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.14% at June 30, 2017 and 2.25% at December 31, 2016.

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

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $167 million and $164 million for the six months ended June 30, 2017 and 2016, respectively.

NOTE 10. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or “whistleblower” lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. We and our subsidiaries have received inquiries in recent years from government agencies, and we may receive similar inquiries in future periods. We are also subject to class action lawsuits, employment-related claims and other legal actions in the ordinary course of business. 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 us or the effect that judgments or settlements in such matters may have on us.

We are also subject to a non-prosecution agreement, as described in our Annual Report. If we fail to comply with this 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.

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

Securities Litigation

On February 10, 2017, the U.S. District Court for the Northern District of Texas consolidated two previously disclosed lawsuits filed by purported shareholders of the Company’s common stock against the Company and several current and former executive officers into a single matter captioned In re Tenet Healthcare Corporation Securities Litigation. On April 11, 2017, the four court-appointed lead plaintiffs filed a consolidated amended class action complaint asserting violations of the federal securities laws. The plaintiffs are seeking class certification on behalf of

all persons who acquired the Company's common stock between February 28, 2012 and August 1, 2016. The complaint alleges that false or misleading statements or omissions concerning the Company's financial performance and compliance policies, specifically with respect to the previously disclosed civil qui tam litigation and parallel criminal investigation of the Company and certain of its subsidiaries (together, the "Clinica de la Mama matters"), caused the price of the Company's common stock to be artificially inflated. In addition, the plaintiffs claim that the defendants violated GAAP by failing to disclose an estimate of the possible loss or a range of loss related to the Clinica de la Mama matters. On June 12, 2017, the Company filed a motion to dismiss the consolidated complaint on behalf of all defendants. The Company intends to vigorously defend against the allegations in the purported shareholder class action.

Shareholder Derivative Litigation

In January 2017, the Dallas County District Court consolidated two previously disclosed shareholder derivative lawsuits filed by purported shareholders of the Company's common stock on behalf of the Company against current and former

Table of Contents

officers and directors into a single matter captioned In re Tenet Healthcare Corporation Shareholder Derivative Litigation. The plaintiffs filed a consolidated shareholder derivative petition in February 2017. A separate shareholder derivative lawsuit, captioned Horwitz, derivatively on behalf of Tenet Healthcare Corporation, was filed in January 2017 in the U.S. District Court for the Northern District of Texas. The consolidated shareholder derivative petition and the Horowitz complaint generally track the allegations in the securities class action complaint described above and claim that the plaintiffs did not make demand on the current directors to bring the lawsuits because such a demand would have been futile. Both shareholder derivative matters were stayed in the second quarter of 2017 pending the final resolution of the motion to dismiss in the consolidated securities litigation. The Company intends to vigorously defend against the allegations in the purported shareholder derivative lawsuits.

Antitrust Class Action Lawsuit Filed by Registered Nurses in San Antonio

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

Ordinary Course Matters

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

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

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the six months ended June 30, 2017 and 2016:

	Balances at Beginning of Period	Litigation and investigation Costs	Cash Payments	Balances at End of Period
Six Months Ended June 30, 2017				
Continuing operations	$ 12	$ 6	$ (13)	$ 5
Discontinued operations	—	—	—	—
	$ 12	$ 6	$ (13)	$ 5
Six Months Ended June 30, 2016				

Continuing operations	$ 299	$ 287	$ (57)	$ 529
Discontinued operations	—	—	—	—
	$ 299	$ 287	$ (57)	$ 529

For the six months ended June 30, 2017 and 2016, we recorded costs of $6 million and $287 million, respectively, in continuing operations in connection with significant legal proceedings and governmental investigations.

NOTE 11. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

As previously disclosed, as part of the formation of our USPI joint venture in 2015, we entered into a put/call agreement (the “Put/Call Agreement”) with respect to the equity interests in the joint venture held by our joint venture partners. In January 2016, Welsh, Carson, Anderson & Stowe (“Welsh Carson”), on behalf of our joint venture partners, delivered a put notice for the minimum number of shares they were required to put to us in 2016 according to the Put/Call Agreement. In

Table of Contents

April 2016, we paid approximately $127 million to purchase those shares, which increased our ownership interest in the USPI joint venture to approximately 56.3%. On May 1, 2017, we amended and restated the Put/Call Agreement to provide for, among other things, the acceleration of our acquisition of certain shares of our USPI joint venture. Under the terms of the amendment, we agreed to pay Welsh Carson, on or before July 3, 2017, approximately $711 million to buy 23.7% of our USPI joint venture, which amount will be subject to adjustment for actual 2017 financial results in accordance with the terms of the Put/Call Agreement. Following the execution of the amendment, we recorded the present value of the liability for this purchase in other current liabilities, with an offset to redeemable noncontrolling interest of $687 million for the carrying amount of the shares and $21 million to additional paid-in capital for the difference between the carrying value and present value of the purchase price for these shares. At June 30, 2017, we had a liability of $716 million recorded in other current liabilities in the accompanying Condensed Consolidated Balance Sheet for the purchase of these shares, as well as the final adjustment to the 2016 purchase price.

The amended and restated Put/Call Agreement also provides that the remaining 15% ownership interest in our USPI joint venture held by our Welsh Carson joint venture partners will be subject to put options in equal shares in each of 2018 and 2019. In the event our Welsh Carson joint venture partners do not exercise these put options, we will have the option, but not the obligation, to buy 7.5% of our USPI joint venture from them in 2018 and another 7.5% in 2019. In connection with such puts or calls, we will have the ability to choose whether to settle the purchase price in cash or shares of our common stock.

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the six months ended June 30, 2017 and 2016:

	Six Months Ended June 30,	
	2017	2016
Balances at beginning of period	$2,393	$2,266
Net income	105	116
Distributions paid to noncontrolling interests	(58)	(44)
Purchase accounting adjustments	—	(47)
Accretion of redeemable noncontrolling interests	29	—
Purchases and sales of businesses and noncontrolling interests, net	(688)	(16)
Balances at end of period	$1,781	$2,275

The following tables show the composition by segment of our redeemable noncontrolling interests balances at June 30, 2017 and December 31, 2016, as well as our net income attributable to redeemable noncontrolling interests for the six months ended June 30, 2017 and 2016:

	June 30, 2017	December 31, 2016
Hospital Operations and other	$ 528	$ 520
Ambulatory Care	1,071	1,715
Conifer	182	158
Redeemable noncontrolling interests	$ 1,781	$ 2,393

	Six Months Ended June 30,	
	2017	2016
Hospital Operations and other	$12	$15
Ambulatory Care	70	78

Conifer	23	23
Net income attributable to redeemable noncontrolling interests	$105	$116

NOTE 12. INCOME TAXES

During the three months ended June 30, 2017, we recorded an income tax benefit of $12 million in continuing operations on pre-tax income of $19 million compared to an income tax benefit of $16 million on pre-tax income of $25 million during the three months ended June 30, 2016. During the six months ended June 30, 2017, we recorded an income tax benefit of $45 million in continuing operations on pre-tax income of $23 million compared to income tax expense of $51 million on pre-tax income of $130 million during the six months ended June 30, 2016. Our provision for income taxes during interim reporting periods is calculated by applying an estimate of the annual effective tax rate for the full year to “ordinary” income or loss (pre-tax income or loss excluding unusual or infrequently occurring discrete items) for the reporting period. In calculating

Table of Contents

“ordinary” income, non-taxable income or loss attributable to non-controlling interests has been deducted from pre-tax income or loss in the determination of the annualized effective tax rate used to calculate income taxes for the quarter. In addition, certain state income taxes have been treated as discrete items in calculating income taxes for the quarter. The reconciliation between the amount of recorded income tax expense (benefit) and the amount calculated at the statutory federal tax rate is shown in the following table:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Tax expense at statutory federal rate of 35%	$7	$9	$8	$46
State income taxes, net of federal income tax benefit	12	(6)	5	7
Tax benefit attributable to noncontrolling interests	(28)	(26)	(54)	(47)
Nondeductible goodwill	—	—	—	29
Nontaxable gains	—	—	—	(17)
Nondeductible litigation	—	7	—	33
Change in tax contingency reserves, including interest	—	—	(2)	(3)
Stock-based compensation	1	—	9	—
Other items	(4)	—	(11)	3
	$(12)	$(16)	$(45)	$51

During the six months ended June 30, 2017, we decreased our estimated liabilities for uncertain tax positions by $2 million, net of related deferred tax assets. The total amount of unrecognized tax benefits at June 30, 2017 was $33 million, of which $30 million, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. Total accrued interest and penalties on unrecognized tax benefits at June 30, 2017 were $4 million, all of which related to continuing operations.

At June 30, 2017, approximately $3 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

Table of Contents

NOTE 13. LOSS PER COMMON SHARE

The following table is a reconciliation of the numerators and denominators of our basic and diluted loss per common share calculations for our continuing operations for three and six months ended June 30, 2017 and 2016. Loss attributable to our common shareholders is expressed in millions and weighted average shares are expressed in thousands.

	Loss Attributable to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended June 30, 2017			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (56)	100,612	$ (0.56)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ (56)	100,612	$ (0.56)
Three Months Ended June 30, 2016			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (44)	99,341	$ (0.44)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ (44)	99,341	$ (0.44)
Six Months Ended June 30, 2017			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (108)	100,306	$ (1.08)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ (108)	100,306	$ (1.08)
Six Months Ended June 30, 2016			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (99)	99,054	$ (1.00)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	$ (99)	99,054	$ (1.00)

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three and six months ended June 30, 2017 and 2016 because we did not report income from continuing operations available to common shareholders in those periods. In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to common

shareholders in the three and six months ended June 30, 2017 and 2016, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 682 and 1,386 for the three months ended June 30, 2017 and 2016, respectively, and 766 and 1,477 for the six months ended June 30, 2017 and 2016, respectively.

NOTE 14. FAIR VALUE MEASUREMENTS

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

Table of Contents

quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

Investments	June 30, 2017	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 54	$ 39	$ 15	$ —
	$ 54	$ 39	$ 15	$ —

Investments	December 31, 2016	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 49	$ 23	$ 26	$ —
	$ 49	$ 23	$ 26	$ —

Our non-financial assets and liabilities not permitted or required to be measured at fair value on a recurring basis typically relate to long-lived assets held and used, long-lived assets held for sale and goodwill. We are required to provide additional disclosures about fair value measurements as part of our financial statements for each major category of assets and liabilities measured at fair value on a non-recurring basis. The following table presents this information and indicates the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities, which generally are not applicable to non-financial assets and liabilities. Fair values determined by Level 2 inputs utilize data points that are observable, such as definitive sales agreements, appraisals or established market values of comparable assets. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability and include situations where there is little, if any, market activity for the asset or liability, such as internal estimates of future cash flows.

	June 30, 2017	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Other than temporarily impaired equity method investments	$ 127	$ —	$ 127	$ —
	$ 127	$ —	$ 127	$ —

	December 31, 2016	Quoted Prices in Active	Significant Other Observable	Significant Unobservable Inputs

		Markets for Identical Assets (Level 1)	Inputs (Level 2)	(Level 3)
Other than temporarily impaired equity method investments	$ 27	$ —	$ 27	$ —
	$ 27	$ —	$ 27	$ —

As described in Note 4, in the six months ended June 30, 2017, we recorded impairment charges in continuing operations of $15 million related to certain of our equity method investments.

The fair value of our long-term debt (except for borrowings under the Credit Agreement) is based on quoted market prices (Level 1). The inputs used to establish the fair value of the borrowings outstanding under the Credit Agreement are considered to be Level 2 inputs, which include inputs other than quoted prices included in Level 1 that are observable, either directly or indirectly. At June 30, 2017 and December 31, 2016, the estimated fair value of our long-term debt was approximately 103.5% and 93.9%, respectively, of the carrying value of the debt.

Table of Contents

NOTE 15. ACQUISITIONS

Preliminary purchase price allocations (representing the fair value of the consideration conveyed) for all acquisitions made during the six months ended June 30, 2017 are as follows:

Current assets	$ 3
Property and equipment	4
Other intangible assets	5
Goodwill	43
Current liabilities	(2)
Long-term liabilities	(1)
Redeemable noncontrolling interests	(10)
Noncontrolling interests	(13)
Cash paid, net of cash acquired	(26)
Gains on consolidations	$ 3

The goodwill generated from these transactions, the majority of which will be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. The goodwill total of $43 million from acquisitions completed during the six months ended June 30, 2017 was recorded in our Ambulatory Care segment. Approximately $2 million in transaction costs related to prospective and closed acquisitions were expensed during the six months ended June 30, 2017 and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statement of Operations.

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

During the six months ended June 30, 2017, we recognized gains totaling $3 million, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

NOTE 16. SEGMENT INFORMATION

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

Our Hospital Operations and other segment is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. We also own various related healthcare businesses.

Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our nine Aspen facilities in the United Kingdom. At June 30, 2017, our USPI joint venture had interests in 241 ambulatory surgery centers, 34 urgent care centers, 22 imaging centers and 20 short-stay 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. At June 30, 2017, Conifer provided services to

more than 800 Tenet and non-Tenet hospitals and other clients nationwide. In 2012, we entered into 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. The pricing terms for the services provided by each party to the other under these contracts were based on estimated third-party pricing terms in effect at the time the agreements were signed.

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

Table of Contents

	June 30, 2017	December 31, 2016
Assets:		
Hospital Operations and other	$17,422	$ 17,871
Ambulatory Care	5,792	5,722
Conifer	1,127	1,108
Total	$24,341	$ 24,701

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Capital expenditures:				
Hospital Operations and other	$136	$184	$319	$375
Ambulatory Care	10	16	21	28
Conifer	4	5	8	10
Total	$150	$205	$348	$413
Net operating revenues:				
Hospital Operations and other total prior to inter-segment eliminations(1)	$4,085	$4,202	$8,200	$8,599
Ambulatory Care	472	442	927	871
Conifer				
Tenet	155	162	314	329
Other customers	245	224	488	442
Total Conifer	400	386	802	771
Inter-segment eliminations	(155)	(162)	(314)	(329)
Total	$4,802	$4,868	$9,615	$9,912
Equity in earnings of unconsolidated affiliates:				
Hospital Operations and other	$(2)	$4	$—	$3
Ambulatory Care	30	26	57	51
Total	$28	$30	$57	$54
Adjusted EBITDA:				
Hospital Operations and other(2)	$346	$427	$655	$845
Ambulatory Care	164	139	317	275
Conifer	60	63	125	126
Total	$570	$629	$1,097	$1,246
Depreciation and amortization:				
Hospital Operations and other	$188	$181	$375	$355
Ambulatory Care	22	22	44	47
Conifer	12	12	24	25
Total	$222	$215	$443	$427
Adjusted EBITDA	$570	$629	$1,097	$1,246
Loss from divested and closed businesses (i.e., the Company's health plan businesses)	(19)	(5)	(35)	(2)
Depreciation and amortization	(222)	(215)	(443)	(427)
Impairment and restructuring charges, and acquisition-related costs	(41)	(22)	(74)	(50)

Litigation and investigation costs	(1)	(114)	(6)	(287)
Interest expense	(260)	(244)	(518)	(487)
Loss from early extinguishment of debt	(26)	—	(26)	—
Other non-operating expense, net	(5)	(5)	(10)	(11)
Gains on sales, consolidation and deconsolidation of facilities	23	1	38	148
Net income from continuing operations before income taxes	$19	$25	$23	$130

(1) Hospital Operations and other revenues includes health plan revenues of $25 million and $90 million for the three and six months ended June 30, 2017, respectively, and $136 million and $263 million for the three and six months ended June 30, 2016, respectively.

(2) Hospital Operations and other Adjusted EBITDA excludes health plan EBITDA of $(19) million and $(35) million for the three and six months ended June 30, 2017, respectively, and $(5) million and $(2) million for the three and six months ended June 30, 2016, respectively.

Table of Contents

NOTE 17. RECENT ACCOUNTING STANDARDS

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). In August 2015, the FASB amended the guidance to defer the effective date of this standard by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. We are currently evaluating the requirements of the new standard to insure that we have processes, systems and internal controls in place to collect the necessary information to implement the standard, which will be effective for us beginning in 2018. It is our current intention to use a modified retrospective method of application to adopt ASU 2014-09. For our Hospital Operations and other and Ambulatory Care segments, we will use a portfolio approach to apply the new model to classes of payers with similar characteristics and will likely revise the approach we use to analyze cash collection trends for certain classes of payers once the final portfolios are determined, including the selection of the appropriate collection look-back period. Adoption of ASU 2014-09 will result in changes to our presentation for and disclosure of revenue related to uninsured or underinsured patients. Currently, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance, in our Hospital Operations and other segment. Under ASU 2014-09, the estimated uncollectable amounts due from these patients will generally be considered a direct reduction to net operating revenues and, correspondingly, will result in a material reduction in the amounts presented separately as provision for doubtful accounts. We are also in the process of assessing the impact of the new standard on various reimbursement programs that represent variable consideration. These include supplemental state Medicaid programs, disproportionate share payments and settlements with third party payers. The payment mechanisms for these types of programs often vary by state. The application of the new standard could have an impact on revenue recognition for variable consideration under these programs. During July 2017, industry guidance surrounding these programs was issued by the American Institute of CPAs' Financial Reporting Executive Committee. Our implementation team is currently reviewing the guidance and comparing it to the existing accounting processes to identify whether changes may be warranted. For our Conifer segment, we expect the adoption of ASU 2014-09 will result in changes to our presentation and disclosure of customer contract assets and liabilities and variable consideration. While the adoption of ASU 2014-09 will have a material effect on the amounts presented in certain categories in our consolidated statements of operations and on our disclosures, we do not expect it to materially impact our financial position, results of operations or cash flows.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)" ("ASU 2016-02"), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and current GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under current GAAP. Recognition of these assets and liabilities will have a material impact to our consolidated balance sheets upon adoption. Under ASU 2016-02, lessees and lessors are required to recognize and measure leases at the beginning of the earliest period presented using a modified retrospective approach, which includes a number of optional practical expedients. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2019.

In January 2017, the FASB issued ASU 2017-04, "Intangibles—Goodwill and Other (Topic 350)" ("ASU 2017-04"), which affects public business and other entities that have goodwill reported in their financial statements and have not elected the private company alternative for the subsequent measurement of goodwill. The amendments in ASU 2017-04 modify the concept of impairment from the condition that exists when the carrying amount of goodwill exceeds its implied fair value to the condition that exists when the carrying amount of a reporting unit exceeds its fair value. An

entity no longer will determine goodwill impairment by calculating the implied fair value of goodwill by assigning the fair value of a reporting unit to all of its assets and liabilities as if that reporting unit had been acquired in a business combination. Because these amendments eliminate Step 2 from the goodwill impairment test, they should reduce the cost and complexity of evaluating goodwill for impairment. It is our intention to early adopt ASU 2017-04 for our annual goodwill impairment tests for the year ending December 31, 2017. As of June 30, 2017, we do not expect the adoption of this guidance to materially impact our financial position, results of operations or cash flows.

Table of Contents

NOTE 18. SUBSEQUENT EVENTS

Long-Term Debt Refinancing Transactions

On June 14, 2017, THC Escrow Corporation III ("Escrow Corp."), a Delaware corporation established for the purpose of issuing the securities referred to in this paragraph, issued $1.040 billion in aggregate principal amount of 4.625% senior secured first lien notes due 2024 (the "Escrow Secured First Lien Notes"), $1.410 billion in aggregate principal amount of 5.125% senior secured second lien notes due 2025 (the "Escrow Secured Second Lien Notes") and $500 million in aggregate principal amount of 7.000% senior unsecured notes due 2025 (the "Escrow Unsecured Notes").

On July 14, 2017, we (i) assumed Escrow Corp.'s obligations with respect to the Escrow Secured Second Lien Notes and (ii) effected a mandatory exchange of all outstanding Escrow Secured First Lien Notes for a like principal amount of our newly issued 2024 Secured First Lien Notes. The proceeds from the sale of the Escrow Secured Second Lien Notes and Escrow Secured First Lien Notes were released from escrow on July 14, 2017 and were used, after payment of fees and expenses, to finance our redemption on July 14, 2017 of $1.041 billion aggregate principal amount of our outstanding 6.250% senior secured notes due 2018 and $1.100 billion aggregate principal amount of our outstanding 5.000% senior unsecured notes due 2019.

On August 1, 2017, we assumed Escrow Corp.'s obligations with respect to the Escrow Unsecured Notes. The proceeds from the sale of the Escrow Unsecured Notes were released from escrow on August 1, 2017 and were used, after payment of fees and expenses, to finance our redemption on August 1, 2017 of $500 million aggregate principal amount of our 8.000% senior unsecured notes due 2020.

As a result of the redemption activities in July and August discussed above, we will record an additional loss from early extinguishment of debt of approximately $132 million in the three months ending September 30, 2017.

Table of Contents

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our Hospital Operations and other segment is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices. Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI joint venture"), in which we own a majority interest, and European Surgical Partners Limited ("Aspen") facilities. At June 30, 2017, our USPI joint venture had interests in 241 ambulatory surgery centers, 34 urgent care centers, 22 imaging centers and 20 short-stay surgical hospitals in 27 states, and Aspen operated nine private hospitals and clinics in the United Kingdom. Our Conifer segment provides healthcare business process services in the areas of 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. MD&A, which should be read in conjunction with the accompanying Condensed Consolidated Financial Statements, includes the following sections:

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

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 75 hospitals operated throughout the six months ended June 30, 2017 and 2016, (ii) five Georgia hospitals, which we divested effective April 1, 2016 , and (iii) The Hospitals of Providence ("THOP") Transmountain Campus, a new teaching hospital we opened on January 17, 2017 in El Paso. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Increased Ownership of our USPI Joint Venture—On May 1, 2017, we amended and restated our Put/Call Agreement, as described and defined in Note 11 to our accompanying Condensed Consolidated Financial Statements, with Welsh, Carson, Anderson & Stowe ("Welsh Carson"), which increased our interest in our USPI joint venture to 80%. Under the terms of the amended and restated Put/Call Agreement, we paid Welsh Carson $716 million on July 3, 2017 comprised of $711 million to buy 23.7% of our USPI joint venture and a $5 million final adjustment payment based on our USPI joint venture's financial performance for calendar year 2016. This payment was made using a combination of cash on hand and borrowings under our revolving credit facility. The $716 million was recorded as

other current liabilities on our Condensed Consolidated Balance Sheet at June 30, 2017. Based on our current forecasts for our USPI joint venture's financial results in 2018 and 2019, we expect to pay Welsh Carson a total of approximately $550 million to $650 million between now and July 2019 to increase our ownership position in our USPI joint venture to 95%; Baylor University Medical Center owns the remaining 5%.

Refinancing Transactions—In June 2017, we commenced certain debt refinancing transactions that are further described in Note 5 and Note 18 to our accompanying Condensed Consolidated Financial Statements. By August 1, 2017, we issued or otherwise became obligated to repay: $1.870 billion in aggregate principal amount of 4.625% senior secured first lien notes due 2024; $1.410 billion in aggregate principal amount of 5.125% senior secured second lien notes due 2025; and $500 million in aggregate principal amount of 7.000% senior unsecured notes due 2025. The proceeds of these new debt issuances were used, after payment of fees and expenses, to finance our redemption of: all $900 million in aggregate principal amount of our outstanding floating rate senior secured notes due 2020; all $1.041 billion in aggregate principal amount of our outstanding 6.250% senior secured notes due 2018; all $1.100 billion in aggregate principal amount of our outstanding

Table of Contents

5.000% senior unsecured notes due 2019; and $500 million in aggregate principal amount of our outstanding 8.000% senior unsecured notes due 2020. As of August 1, 2017, our total long-term debt included $6.070 billion in aggregate principal amount of senior secured first lien notes, $2.160 billion in aggregate principal amount of senior secured second lien notes, and $6.680 billion in aggregate principal amount of senior unsecured notes.

Divestiture of Three Acute Care Hospitals and Related Operations in Houston—On July 31, 2017, we completed our previously announced sale of our Houston-area acute care hospitals and related operations to HCA Healthcare, Inc. for net pre-tax proceeds of approximately $750 million in cash. The effective date of the sale was August 1, 2017. Substantially all of the assets related to the ownership and operation of Cypress Fairbanks Medical Center, Park Plaza Hospital and Plaza Specialty Hospital were sold as part of the transaction, along with our equity interest in the subsidiary that owns Houston Northwest Medical Center, as well as certain other hospital-affiliated entities, including physician practices. The cash consideration is subject to certain purchase price adjustments relating to, among other things, final net working capital adjustments and actual collections of accounts receivable over the subsequent 18 month period compared to the agreed-upon amount of future cash collections used at closing.

TRENDS AND STRATEGIES

The healthcare industry, in general, and the acute care hospital business, in particular, are experiencing significant regulatory uncertainty based, in large part, on legislative 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 these actions on our future revenues and operations. However, we believe that our ultimate success in increasing our profitability depends in part on our success in executing the strategies discussed below. In general, these strategies are intended to address the following trends shaping the demand for healthcare services: (i) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (ii) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (iii) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (iv) consolidation continues across the entire healthcare sector through both traditional acquisition and divestiture activities, as well as joint ventures.

Driving Growth in Our Facilities—Over the past several years, and with the aforementioned trends in mind, we have taken a number of steps to better position our hospitals, ambulatory care centers and other outpatient businesses to compete more effectively in the ever evolving healthcare environment. We have set competitive prices for our services, made capital and other investments in our facilities and technology, increased our efforts to recruit and retain quality physicians, nurses and other healthcare personnel, and negotiated competitive contracts with managed care and other private payers. In addition, we have expanded our network of outpatient centers, and we have increased the participation of our hospitals in accountable care organizations (“ACOs”), which are networks of providers and suppliers that work together to invest in infrastructure and to redesign delivery processes in an effort to achieve high quality and efficient delivery of services. We have also entered into joint ventures with other healthcare providers in several of our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

We believe we are well-positioned to generate returns on recent hospital projects, including our new 106-bed teaching hospital in El Paso, which opened on January 17, 2017. We are also continuing our strategy of selling assets in non-core markets, as well as sub-scale businesses, such as our health plans. We will continue to further refine our portfolio of hospitals and related healthcare businesses when we believe such refinements will help us achieve one or more of the following goals: improve profitability; allocate capital more effectively in areas where we have a stronger market presence; deploy proceeds on higher-return investments across our business; enhance cash generation; and lower our ratio of debt-to-Adjusted EBITDA.

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 surgery centers and surgical hospitals like those in our USPI joint venture 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 steadily increase. In addition, we have continued to grow our imaging and urgent care businesses through our USPI joint venture's acquisitions. These acquisitions 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.

Table of Contents

Driving Conifer's Growth—We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and value-based care services businesses. Conifer provides services to more than 800 Tenet and non-Tenet hospital and other clients nationwide. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward ACOs and similar risk-based or capitated contract models. In addition to hospitals and independent physician associations, clients for these services include health plans, self-insured organizations, government agencies and other entities.

Improving Operating Leverage—We are focused on improving profitability by growing patient volumes and effective cost management. We believe our patient volumes have been constrained 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 and deductibles, and depressed economic conditions and demographic trends in certain of our markets. However, we also believe that targeted capital spending on growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our outpatient business and the implementation of new payer contracting strategies should help us grow our patient volumes. In addition, we believe our capital structure will withstand a changing interest rate environment. As of August 1, 2017, all of our long-term debt has a fixed rate of interest, and the maturity dates of our notes are staggered from 2019 through 2031. Moreover, we intend to lower our ratio of debt-to-Adjusted EBITDA, primarily through 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 manage 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 our Annual Report on Form 10-K for the year ended December 31, 2016 ("Annual Report").

RESULTS OF OPERATIONS—OVERVIEW

The following tables show certain selected operating statistics for our continuing operations, which includes the results of (i) our same 75 hospitals operated throughout the six months ended June 30, 2017 and 2016, (ii) five Georgia hospitals, which we divested effective April 1, 2016, and (iii) our new THOP Transmountain Campus teaching hospital, which we opened on January 17, 2017 in El Paso. We believe this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses.

Table of Contents

Selected Operating Statistics	Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	
Hospital Operations and other – acute care hospitals and related outpatient facilities				
Number of hospitals (at end of period)	76	75	1	(1)
Total admissions	190,394	193,898	(1.8)%	
Adjusted patient admissions(2)	342,439	342,813	(0.1)%	
Paying admissions (excludes charity and uninsured)	179,889	183,539	(2.0)%	
Charity and uninsured admissions	10,505	10,359	1.4 %	
Emergency department visits	724,785	715,692	1.3 %	
Total surgeries	123,449	130,201	(5.2)%	
Patient days — total	874,930	897,313	(2.5)%	
Adjusted patient days(2)	1,552,302	1,569,272	(1.1)%	
Average length of stay (days)	4.60	4.63	(0.6)%	
Average licensed beds	20,435	20,380	0.3 %	
Utilization of licensed beds(3)	47.0 %	48.4 %	(1.4)%	(1)
Total visits	1,981,848	2,038,287	(2.8)%	
Paying visits (excludes charity and uninsured)	1,849,697	1,896,394	(2.5)%	
Charity and uninsured visits	132,151	141,893	(6.9)%	
Ambulatory Care				
Total consolidated facilities (at end of period)	219	214	5	(1)
Total cases	462,174	444,955	3.9 %	

(1) The change is the difference between the 2017 and 2016 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 3,504, or 1.8%, in the three months ended June 30, 2017 compared to the three months ended June 30, 2016, and total surgeries decreased by 6,752, or 5.2%, in the three months ended June 30, 2017 compared to the 2016 period. Our emergency department visits increased 1.3% in the three months ended June 30, 2017 compared to the same period in the prior year. Our volumes from continuing operations in the three months ended June 30, 2017 compared to the three months ended June 30, 2016 were negatively impacted by our out-of-network status with a national payer for most of the 2017 period. Our Ambulatory Care total cases increased 3.9% due to the increase in consolidated facilities.

	Continuing Operations Three Months Ended June 30,			
Revenues	2017	2016	Increase (Decrease)	
Net operating revenues before provision for doubtful accounts				
Hospital Operations and other prior to inter-segment eliminations	$4,445	$4,544	(2.2	)%
Ambulatory Care	483	452	6.9	%
Conifer	400	386	3.6	%
Inter-segment eliminations	(155)	(162)	(4.3	)%
Total	$5,173	$5,220	(0.9	)%
Selected Hospital Operations and other – acute care hospitals and related outpatient facilities revenue data				
Net inpatient revenues	$2,555	$2,588	(1.3	)%
Net outpatient revenues	1,511	1,460	3.5	%
Net patient revenues	$4,066	$4,048	0.4	%
Self-pay net inpatient revenues	$113	$118	(4.2	)%
Self-pay net outpatient revenues	162	131	23.7	%
Total self-pay revenues	$275	$249	10.4	%

Net operating revenues before provision for doubtful accounts decreased by $47 million, or 0.9%, in the three months ended June 30, 2017 compared to the same period in 2016, primarily due to lower inpatient and outpatient volumes, as described above. The 2016 period also included $57 million of net revenues from the California provider fee program compared to no revenues under the program in the 2017 period because CMS has not yet approved the 2017 program. For our Hospital

29

Table of Contents

Operations and other segment, the impact of lower volumes on net operating revenues was partially mitigated by improved managed care pricing.

Provision for Doubtful Accounts	Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	
Provision for doubtful accounts				
Hospital Operations and other	$360	$342	5.3	%
Ambulatory Care	11	10	10.0	%
Total	$371	$352	5.4	%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts				
Hospital Operations and other	8.1 %	7.5 %	0.6 %	(1)
Ambulatory Care	2.3 %	2.2 %	0.1 %	(1)
Total	7.2 %	6.7 %	0.5 %	(1)

(1) The change is the difference between the 2017 and 2016 amounts shown.

Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.2% and 6.7% for the three months ended June 30, 2017 and 2016, respectively. This increase was primarily due to increases in uninsured revenues. Our accounts receivable days outstanding (“AR Days”) from continuing operations (which calculation includes the accounts receivable of our Houston-area facilities that have been classified in assets held for sale on our Condensed Consolidated Balance Sheet at June 30, 2017, excludes our health plan revenues and excludes our California provider fee revenue from the 2016 period because the 2017 program has not yet been approved) were 53.6 days at June 30, 2017 and 56.7 days at December 31, 2016, compared to our target of less than 55 days.

Selected Operating Expenses	Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	
Hospital Operations and other				
Salaries, wages and benefits	$1,943	$1,924	1.0	%
Supplies	682	682	—	%
Other operating expenses	982	1,037	(5.3	)%
Total	$3,607	$3,643	(1.0	)%
Ambulatory Care				
Salaries, wages and benefits	$153	$147	4.1	%
Supplies	96	91	5.5	%
Other operating expenses	89	91	(2.2	)%

Total	$338	$329	2.7	%
Conifer				
Salaries, wages and benefits	$250	$238	5.0	%
Supplies	2	—	100.0	%
Other operating expenses	88	85	3.5	%
Total	$340	$323	5.3	%
Total				
Salaries, wages and benefits	$2,346	$2,309	1.6	%
Supplies	780	773	0.9	%
Other operating expenses	1,159	1,213	(4.5	)%
Total	$4,285	$4,295	(0.2	)%
Rent/lease expense(1)				
Hospital Operations and other	$61	$61	—	%
Ambulatory Care	19	20	(5.0	)%
Conifer	5	5	—	%
Total	$85	$86	(1.2	)%

(1) Included in other operating expenses.

Table of Contents

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	
Hospital Operations and other				
Salaries, wages and benefits per adjusted patient admission(1)	$5,662	$5,595	1.2	%
Supplies per adjusted patient admission(1)	1,995	1,983	0.6	%
Other operating expenses per adjusted patient admission(1)	2,737	2,579	6.1	%
Total per adjusted patient admission	$10,394	$10,157	2.3	%

(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 1.2% in the three months ended June 30, 2017 compared to the same period in 2016. This change is primarily due to annual merit increases for certain of our employees and the effect of lower volumes on operating leverage due to certain fixed staffing costs, partially offset by the impact of recent favorable workers' compensation claims experience.

Supplies expense per adjusted patient admission increased 0.6% in the three months ended June 30, 2017 compared to the three months ended June 30, 2016. The change in supplies expense was primarily attributable to increased costs from our higher acuity supply-intensive surgical services, partially offset by the benefit of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

Other operating expenses per adjusted patient admission increased by 6.1% in the three months ended June 30, 2017 compared to the prior-year period. This increase is due to higher contracted services and medical fees, increased malpractice expense, and increased costs associated with funding indigent care services, which costs were substantially offset by additional net patient revenues, as well as the effect of lower volumes on operating leverage due to certain fixed costs. These increases were partially offset by gains on the sales of assets (primarily home health and hospice assets), and decreased expenses associated with our health plan businesses due to the sale and wind-down of these businesses in 2017. Malpractice expense for our Hospital Operations and other segment was $26 million higher in the 2017 period compared to the 2016 period. In the 2017 period, we recognized an unfavorable adjustment of approximately $2 million from the eight basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities. In the 2016 period, we recognized an unfavorable adjustment of approximately $6 million from the 25 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $475 million at June 30, 2017 compared to $572 million at March 31, 2017.

Significant cash flow items in the three months ended June 30, 2017 included:

- Net cash provided by operating activities before interest, taxes and restructuring charges, acquisition-related costs, and litigation costs and settlements of $634 million;

- Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements of $38 million;

- Capital expenditures of $150 million;

- Proceeds from the sale of facilities and other assets of $54 million;

- Interest payments of $338 million;

- Income tax payments of $43 million;

- $830 million of proceeds from the issuance of our 4.625% senior secured notes due 2024;

- $912 million of payments to defease our floating rate senior secured notes due 2020;

- $27 million of payments for debt issuance costs; and

31

Table of Contents

- $60 million of distributions paid to noncontrolling interests.

Net cash provided by operating activities was $401 million in the six months ended June 30, 2017 compared to $582 million in the six months ended June 30, 2016. Key factors contributing to the change between the 2017 and 2016 periods include the following:

- Decreased income from continuing operations before income taxes of $149 million, excluding investment earnings (losses), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, depreciation and amortization, and income (loss) from divested operations and closed businesses (i.e., our health plan businesses) in the six months ended June 30, 2017 compared to the six months ended June 30, 2016;

- A $37 million decrease in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;

- Reduced cash flows from our health plan businesses of $65 million due to cash outflows in the 2017 period resulting from the sales and wind-down of these businesses in 2017, compared to slightly positive cash flows in the 2016 period; and

- The timing of other working capital items.

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

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

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

HOSPITAL OPERATIONS AND OTHER SEGMENT SOURCES OF REVENUE

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

The following table shows the sources of net patient revenues before provision for doubtful accounts for our acute care hospitals and related outpatient facilities, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

Table of Contents

	Three Months Ended June 30,			Six Months Ended June 30,		
Net Patient Revenues from:	2017	2016	Increase (Decrease) (1)	2017	2016	Increase (Decrease) (1)
Medicare	20.1%	21.7%	(1.6)%	20.6%	20.8%	(0.2)%
Medicaid	6.9%	7.4%	(0.5)%	6.8%	8.0%	(1.2)%
Managed care	62.5%	59.4%	3.1%	62.4%	60.4%	2.0%
Indemnity, self-pay and other	10.5%	11.5%	(1.0)%	10.2%	10.8%	(0.6)%

(1) The increase (decrease) is the difference between the 2017 and 2016 percentages shown.

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

	Three Months Ended June 30,			Six Months Ended June 30,		
Admissions from:	2017	2016	Increase (Decrease) (1)	2017	2016	Increase (Decrease) (1)
Medicare	25.9%	25.9%	—%	26.5%	26.6%	(0.1)%
Medicaid	6.5%	6.7%	(0.2)%	6.5%	7.0%	(0.5)%
Managed care	59.7%	59.4%	0.3%	59.3%	58.7%	0.6%
Indemnity, self-pay and other	7.9%	8.0%	(0.1)%	7.7%	7.7%	—%

(1) The increase (decrease) is the difference between the 2017 and 2016 percentages shown.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services (“CMS”), 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 55 million individuals rely on healthcare benefits through Medicare, and approximately 74 million individuals are enrolled in

Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and directed by CMS. Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage. Unlike Medicaid, the CHIP is limited in duration and periodically requires the enactment of reauthorizing legislation. The current authorizing legislation will expire on September 30, 2017, and we cannot predict what action the federal government may take with regard to the continuation of the CHIP.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues from continuing operations of our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the three and six months ended June 30, 2017 and 2016 are set forth in the following table:

Table of Contents

	Three Months Ended June 30,		Six Months Ended June 30,	
Revenue Descriptions	2017	2016	2017	2016
Medicare severity-adjusted diagnosis-related group — operating	$410	$415	$860	$889
Medicare severity-adjusted diagnosis-related group — capital	37	38	78	81
Outliers	22	16	43	38
Outpatient	224	252	465	474
Disproportionate share	68	72	139	150
Direct Graduate and Indirect Medical Education(1)	65	61	131	125
Other(2)	12	44	12	27
Adjustments for prior-year cost reports and related valuation allowances	14	17	26	30
Total Medicare net patient revenues	$852	$915	$1,754	$1,814

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

(2) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments,

and adjustments related to the estimates for current-year cost reports and related valuation allowances.

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

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 17.7% and 18.5% of total net patient revenues before provision for doubtful accounts of our acute care hospitals and related outpatient facilities for the six months ended June 30, 2017 and 2016, respectively. We also receive disproportionate share hospital (“DSH”) and other supplemental revenues under various state Medicaid programs. For the six months ended June 30, 2017 and 2016, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately $322 million and $442 million, respectively. The 2017 period included $113 million related the Michigan provider fee program, $70 million related to Medicaid DSH programs in multiple states, $68 million related to the Texas 1115 waiver program, and $71 million from a number of other state and local programs. The 2016 period included $112 million from the 36-month California provider fee program, which ended on December 31, 2016, compared to no revenues under the 30-month program, which covers the period from January 1, 2017 through June 30, 2019, in the 2017 period because CMS has not yet approved the 30-month program.

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

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

Medicaid-related patient revenues from continuing operations recognized by our Hospital Operations and other segment from Medicaid-related programs in the states in which our facilities are located, as well as from Medicaid

programs in neighboring states, for the six months ended June 30, 2017 and 2016 are set forth in the following table:

34

Table of Contents

	Six Months Ended June 30,			
	2017		2016	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Alabama	$55	$ —	$40	$ —
Arizona	(1)	107	(1)	110
California	84	219	191	216
Florida	38	89	36	86
Georgia	—	—	13	9
Illinois	37	38	34	36
Massachusetts	15	27	19	29
Michigan	190	176	189	155
Missouri	—	1	—	—
North Carolina	—	—	(2)	—
Pennsylvania	40	121	36	118
South Carolina	7	19	8	19
Tennessee	2	16	2	17
Texas	99	125	105	127
	$566	$ 938	$670	$ 922

Regulatory and Legislative Changes

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

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

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year ("FFY"). On August 2, 2017, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2018 Rates ("Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.7% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record ("EHR") technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS is also proposing certain adjustments to the estimated 2.7% market basket increase that result in a net operating payment update of 1.21% (before budget neutrality adjustments), including:
  - Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.6%, respectively;
  - A 0.4588% increase required under the 21st Century Cures Act; and
  - A reduction of 0.6% to reverse the one-time increase of 0.6% made in FFY 2017 to address the effects of the 0.2% reduction in effect for FFYs 2014 through 2016 related to the two-midnight rule.
- Updates to the three factors used to determine the amount and distribution of Medicare uncompensated care disproportionate share ("UC-DSH") payments, including a transition from using low-income days to estimated uncompensated care costs for the distribution of the UC-DSH pool;
- A 1.61% net increase in the capital federal MS-DRG rate; and
- An increase in the cost outlier threshold from $23,573 to $26,601.

According to CMS, the combined impact of the payment and policy changes in the Final IPPS Rule for operating costs will yield an average 1.4% increase in Medicare operating MS-DRG fee-for-service (“FFS”) payments for hospitals in large urban areas (populations over one million) in FFY 2018. We estimate that all of the payment and policy changes affecting operating MS-DRG payments, notably those affecting Medicare UC-DSH payments, will result in an estimated 0.1% increase in our annual Medicare FFS IPPS payments, which yields an estimated increase of approximately $2 million. The payment

Table of Contents

increase resulting from the 1.21% net market basket increase is offset by a reduction to our UC-DSH payments primarily due to the aforementioned transition to using uncompensated care costs for the distribution of the UC-DSH pool. Because of the uncertainty associated with various factors that may influence our future IPPS payments by individual hospital, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the final payment and policy changes.

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

On July 13, 2017, CMS released proposed policy changes, quality provisions and payment rates for the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year 2018 ("Proposed OPPS/ASC Rule"). The Proposed OPPS/ASC rule includes the following payment and policy changes:

- An estimated net increase in the OPPS rates of 1.75% 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 0.4%, respectively;

- A proposal to remove total knee arthroplasty ("TKA") from the CMS list of procedures that can be performed only on an inpatient basis (the "Inpatient Only List"); if finalized, this policy would permit TKAs to be performed in a hospital outpatient department; CMS is also soliciting public comments on whether the TKA procedure meets the criteria to be added to the ASC list of covered surgical procedures; and

- A 1.9% update to the ASC payment rates.

CMS is also seeking public comments on: (1) whether it should consider for future rulemaking possible removal of partial hip arthroplasty ("PHA") and total hip arthroplasty ("THA) from the Inpatient Only List; and (2) whether PHA and THA procedures meet the criteria to be added to the ASC list of covered procedures.

CMS projects that the combined impact of the payment and policy changes in the Proposed OPPS/ASC Rule will yield an average 2.0% increase in Medicare FFS OPPS payments for all hospitals and an average 1.9% increase in Medicare FFS OPPS payments for hospitals in large urban areas (populations over one million). Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Proposed OPPS/ASC Rule on our hospitals is an increase to Medicare FFS hospital outpatient revenues of approximately $13 million, which represents an increase of approximately 2%. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative action, volumes and case mix, as well as potential changes to the proposed rule, we cannot provide any assurances regarding our estimate of the impact of the proposed changes.

PRIVATE INSURANCE

Managed Care

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

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

The amount of our managed care net patient revenues from our Hospital Operations and other segment during the six months ended June 30, 2017 and 2016 was $5.343 billion and $5.302 billion, respectively. Approximately 61% of our managed care net patient revenues for the six months ended June 30, 2017 was derived from our top ten managed care payers. National

Table of Contents

payers generated approximately 47% of our total net managed care revenues. The remainder comes from regional or local payers. At June 30, 2017 and December 31, 2016, approximately 62% and 63%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

In April 2017, we successfully concluded negotiations with a national payer to return to its provider network after ceasing our participation on October 1, 2016. As a result of this new agreement, our hospitals and other healthcare facilities, as well as our employed physicians, were all added to the payer's national provider network on June 1, 2017. Prior to expiration of the contract on October 1, 2016, the contract represented approximately 2.9% of our net operating revenues before provision for doubtful accounts for the period subsequent to the sale of our Georgia hospitals on March 31, 2016 to the contract expiration on September 30, 2016.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at June 30, 2017, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $17 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have 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 six months ended June 30, 2017, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 85% 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, 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 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 June 30, 2017 and December 31, 2016, approximately 6% and 5%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co pays and

Table of Contents

deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which is subject to various laws, rules and regulations regarding consumer finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, in Part I of our Annual 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 provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have increased our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We 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 provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are 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) 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, which exclude the costs of our health plan businesses) 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 three and six months ended June 30, 2017 and 2016:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Estimated costs for:				
Self-pay patients	$160	$151	$320	$295
Charity care patients	33	29	63	68
Total	$193	$180	$383	$363

Medicaid DSH and other supplemental revenues	$164	$215	$322	$442

The expansion of health insurance coverage has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, 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 illegally who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

Table of Contents

RESULTS OF OPERATIONS

The following two tables summarize our 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 three and six months ended June 30, 2017 and 2016:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Net operating revenues:				
General hospitals	$4,084	$4,062	$8,179	$8,364
Other operations	1,089	1,158	2,190	2,276
Net operating revenues before provision for doubtful accounts	5,173	5,220	10,369	10,640
Less provision for doubtful accounts	371	352	754	728
Net operating revenues	4,802	4,868	9,615	9,912
Equity in earnings of unconsolidated affiliates	28	30	57	54
Operating expenses:				
Salaries, wages and benefits	2,346	2,309	4,726	4,704
Supplies	780	773	1,545	1,584
Other operating expenses, net	1,159	1,213	2,346	2,455
Electronic health record incentives	(6)	(21)	(7)	(21)
Depreciation and amortization	222	215	443	427
Impairment and restructuring charges, and acquisition-related costs	41	22	74	50
Litigation and investigation costs	1	114	6	287
Gains on sales, consolidation and deconsolidation of facilities	(23)	(1)	(38)	(148)
Operating income	$310	$274	$577	$628

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Net operating revenues	100.0 %	100.0 %	100.0 %	100.0 %
Equity in earnings of unconsolidated affiliates	0.6 %	0.6 %	0.6 %	0.5 %
Operating expenses:				
Salaries, wages and benefits	48.9 %	47.4 %	49.2 %	47.5 %
Supplies	16.2 %	15.9 %	16.1 %	16.0 %
Other operating expenses, net	24.1 %	24.9 %	24.4 %	24.8 %
Electronic health record incentives	(0.1)%	(0.4)%	(0.1)%	(0.2)%
Depreciation and amortization	4.6 %	4.4 %	4.6 %	4.3 %
Impairment and restructuring charges, and acquisition-related costs	0.9 %	0.5 %	0.8 %	0.5 %
Litigation and investigation costs	— %	2.3 %	0.1 %	2.9 %
Gains on sales, consolidation and deconsolidation of facilities	(0.5)%	— %	(0.4)%	(1.5)%
Operating income	6.5 %	5.6 %	6.0 %	6.3 %

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) our Ambulatory Care segment, (4) services provided by our Conifer subsidiary to third parties and (5) our health plans. Revenues from our general hospitals represented approximately

79% and 78% of our total net operating revenues before provision for doubtful accounts for the three months ended June 30, 2017 and 2016, respectively, and 79% for both of the six month periods ended June 30, 2017 and 2016.

Net operating revenues from our other operations were $1.089 billion and $1.158 billion in the three months ended June 30, 2017 and 2016, respectively, and $2.190 billion and $2.276 billion in the six months ended June 30, 2017 and 2016, respectively. The decrease in net operating revenues from other operations during 2017 primarily relates to our health plans, partially offset by increases in revenue cycle services provided by our Conifer subsidiary and revenues from our USPI joint venture. Equity earnings of unconsolidated affiliates were $28 million and $30 million for the three months ended June 30, 2017 and 2016, respectively, and $57 million and $54 million for the six months ended June 30, 2017 and 2016, respectively.

Table of Contents

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 75 hospitals operated throughout the six months ended June 30, 2017 and 2016. The results of five Georgia hospitals, which we divested effective April 1, 2016, and our new THOP Transmountain Campus teaching hospital, which we opened on January 17, 2017 in El Paso, are excluded from our same-hospital information.

	Three Months Ended June 30,			Six Months Ended June 30,		
Selected Operating Expenses	2017	2016	Increase (Decrease)	2017	2016	Increase (Decrease)
Hospital Operations and other — Same-Hospital						
Salaries, wages and benefits	$1,930	$1,917	0.7 %	$3,897	$3,845	1.4 %
Supplies	680	681	(0.1)%	1,348	1,383	(2.5)%
Other operating expenses	966	1,022	(5.5)%	1,966	2,042	(3.7)%
Total	$3,576	$3,620	(1.2)%	$7,211	$7,270	(0.8)%
Ambulatory Care						
Salaries, wages and benefits	$153	$147	4.1 %	$303	$293	3.4 %
Supplies	95	91	4.4 %	189	177	6.8 %
Other operating expenses	89	91	(2.2)%	174	177	(1.7)%
Total	$337	$329	2.4 %	$666	$647	2.9 %
Conifer						
Salaries, wages and benefits	$250	$238	5.0 %	$500	$477	4.8 %
Supplies	2	—	100.0 %	2	—	100.0 %
Other operating expenses	88	85	3.5 %	175	168	4.2 %
Total	$340	$323	5.3 %	$677	$645	5.0 %
Total						
Salaries, wages and benefits	$2,333	$2,302	1.3 %	$4,700	$4,615	1.8 %
Supplies	777	772	0.6 %	1,539	1,560	(1.3)%
Other operating expenses	1,143	1,198	(4.6)%	2,315	2,387	(3.0)%
Total	$4,253	$4,272	(0.4)%	$8,554	$8,562	(0.1)%
Rent/lease expense (1)						
Hospital Operations and other	$59	$59	— %	$119	$118	0.8 %
Ambulatory Care	19	20	(5.0)%	37	37	— %
Conifer	5	5	— %	10	9	11.1 %
Total	$83	$84	(1.2)%	$166	$164	1.2 %

(1) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported in three segments:

- Hospital Operations and other, which is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals and physician practices;
- Ambulatory Care, which is comprised of our USPI joint venture's ambulatory surgery centers, urgent care centers, imaging centers and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; and
- Conifer, which 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.

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations acute care hospitals and related outpatient facilities on a same-hospital basis, unless otherwise indicated, which includes the results of our same 75 hospitals operated throughout the six months ended June 30, 2017 and 2016. The results of five Georgia hospitals, which we divested effective April 1, 2016, and our new THOP Transmountain Campus teaching hospital, which we opened on January 17, 2017 in El Paso, are excluded from our same-hospital information.

Table of Contents

Admissions, Patient Days and Surgeries	Same-Hospital Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	Same-Hospital Continuing Operations Six Months Ended June 30, 2017	2016	Increase (Decrease)
Number of hospitals (at end of period)	75	75	— (1)	75	75	— (1)
Total admissions	189,473	193,779	(2.2)%	385,655	396,652	(2.8)%
Adjusted patient admissions(2)	335,915	340,792	(1.4)%	675,437	689,013	(2.0)%
Paying admissions (excludes charity and uninsured)	179,101	183,474	(2.4)%	365,180	376,760	(3.1)%
Charity and uninsured admissions	10,372	10,305	0.7 %	20,475	19,892	2.9 %
Admissions through emergency department	121,212	122,239	(0.8)%	247,279	251,845	(1.8)%
Paying admissions as a percentage of total admissions	94.5 %	94.7 %	(0.2)% (1)	94.7 %	95.0 %	(0.3)% (1)
Charity and uninsured admissions as a percentage of total admissions	5.5 %	5.3 %	0.2 % (1)	5.3 %	5.0 %	0.3 % (1)
Emergency department admissions as a percentage of total admissions	64.0 %	63.1 %	0.9 % (1)	64.1 %	63.5 %	0.6 % (1)
Surgeries — inpatient	51,913	54,376	(4.5)%	103,636	108,115	(4.1)%
Surgeries — outpatient	71,253	75,825	(6.0)%	140,806	150,185	(6.2)%
Total surgeries	123,166	130,201	(5.4)%	244,442	258,300	(5.4)%
Patient days — total	871,816	897,127	(2.8)%	1,792,830	1,858,125	(3.5)%
Adjusted patient days(2)	1,538,940	1,568,680	(1.9)%	3,122,902	3,206,088	(2.6)%
Average length of stay (days)	4.60	4.63	(0.6)%	4.65	4.68	(0.6)%
Licensed beds (at end of period)	20,329	20,380	(0.3)%	20,329	20,380	(0.3)%
Average licensed beds	20,329	20,380	(0.3)%	20,331	20,378	(0.2)%
Utilization of licensed beds(3)	47.1 %	48.4 %	(1.3)% (1)	48.7 %	50.4 %	(1.7)% (1)

(1) The change is the difference between 2017 and 2016 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.

	Same-Hospital Continuing Operations Three Months Ended June 30,			Same-Hospital Continuing Operations Six Months Ended June 30,		
Outpatient Visits	2017	2016	Increase (Decrease)	2017	2016	Increase (Decrease)
Total visits	1,950,251	2,025,946	(3.7)%	3,959,659	4,078,115	(2.9)%
Paying visits (excludes charity and uninsured)	1,823,601	1,884,716	(3.2)%	3,706,836	3,792,714	(2.3)%
Charity and uninsured visits	126,650	141,230	(10.3)%	252,823	285,401	(11.4)%
Emergency department visits	694,213	703,276	(1.3)%	1,397,248	1,437,032	(2.8)%
Surgery visits	71,253	75,825	(6.0)%	140,806	150,185	(6.2)%
Paying visits as a percentage of total visits	93.5%	93.0%	0.5 %(1)	93.6%	93.0%	0.6 %(1)
Charity and uninsured visits as a percentage of total visits	6.5%	7.0%	(0.5)%(1)	6.4%	7.0%	(0.6)%(1)

(1) The change is the difference between 2017 and 2016 amounts shown.

Table of Contents

Revenues	Same-Hospital Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	Same-Hospital Continuing Operations Six Months Ended June 30, 2017	2016	Increase (Decrease)
Total segment net operating revenues	$3,900	$4,026	(3.1)%	$7,837	$8,086	(3.1)%
Selected acute care hospitals and related outpatient facilities revenue data						
Net inpatient revenues	$2,545	$2,568	(0.9)%	$5,150	$5,231	(1.5)%
Net outpatient revenues	1,491	1,451	2.8 %	2,954	2,896	2.0 %
Net patient revenues	$4,036	$4,019	0.4 %	$8,104	$8,127	(0.3)%
Self-pay net inpatient revenues	$112	$114	(1.8)%	$218	$187	16.6 %
Self-pay net outpatient revenues	161	134	20.1 %	311	270	15.2 %
Total self-pay revenues	$273	$248	10.1 %	$529	$457	15.8 %

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)	Same-Hospital Continuing Operations Six Months Ended June 30, 2017	2016	Increase (Decrease)
Net inpatient revenue per admission	$13,432	$13,252	1.4 %	$13,354	$13,188	1.3 %
Net inpatient revenue per patient day	$2,919	$2,862	2.0 %	$2,873	$2,815	2.1 %
Net outpatient revenue per visit	$765	$716	6.8 %	$746	$710	5.1 %
Net patient revenue per adjusted patient admission(1)	$12,015	$11,793	1.9 %	$11,998	$11,795	1.7 %
Net patient revenue per adjusted patient day(1)	$2,623	$2,562	2.4 %	$2,595	$2,535	2.4 %

(1) 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.

Total Segment Provision for Doubtful Accounts	Same-Hospital Continuing Operations Three Months Ended June 30,			Same-Hospital Continuing Operations Six Months Ended June 30,		
	2017	2016	Increase (Decrease)	2017	2016	Increase (Decrease)
Provision for doubtful accounts	$358	$327	9.5 %	$730	$665	9.8 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	8.4 %	7.5 %	0.9 % (1)	8.5 %	7.6 %	0.9 % (1)

(1) The change is the difference between 2017 and 2016 amounts shown.

Table of Contents

Total Segment Selected Operating Expenses	Same-Hospital Continuing Operations Three Months Ended June 30, 2017	2016	Increase (Decrease)		Same-Hospital Continuing Operations Six Months Ended June 30, 2017	2016	Increase (Decrease)	
Salaries, wages and benefits as a percentage of net operating revenues	49.5%	47.6%	1.9	% (1)	49.7%	47.6%	2.1	% (1)
Supplies as a percentage of net operating revenues	17.4%	16.9%	0.5	% (1)	17.2%	17.1%	0.1	% (1)
Other operating expenses as a percentage of net operating revenues	24.8%	25.4%	(0.6)	% (1)	25.1%	25.3%	(0.2)	% (1)

(1) The change is the difference between 2017 and 2016 amounts shown.

Revenues

Same-hospital net operating revenues decreased $126 million, or 3.1%, during the three months ended June 30, 2017 compared to the three months ended June 30, 2016, primarily due to lower inpatient and outpatient volumes. Our 2017 same-hospital inpatient and outpatient volumes were negatively impacted compared to the 2016 period by our out-of-network status with a national payer for most of the 2017 period. The 2016 period also included $55 million of net revenues from the California provider fee program compared to no revenues under the program in the 2017 period because CMS has not yet approved the 2017 program. Same-hospital net inpatient revenues decreased $23 million, or 0.9%, and same-hospital admissions decreased 2.2% in the three months ended June 30, 2017 compared to the same period in 2016. Same-hospital net inpatient revenue per admission increased 1.4%, primarily due to the improved terms of our managed care contracts in the three months ended June 30, 2017 compared to the three months ended June 30, 2016. Same-hospital net outpatient revenues increased $40 million, or 2.8%, while same-hospital outpatient visits decreased 3.7% in the three months ended June 30, 2017 compared to the same period in 2016 due in part to the sale of home health and hospice assets. Growth in outpatient revenues was primarily driven by improved terms of our managed care contracts. Same-hospital net outpatient revenue per visit increased 6.8% in the three months ended June 30, 2017 compared to the three months ended June 30, 2016, primarily due to the improved terms of our managed care contracts and the sale of home health and hospice assets.

Same-hospital net operating revenues decreased $249 million, or 3.1%, during the six months ended June 30, 2017 compared to the six months ended June 30, 2016, primarily due to lower inpatient and outpatient volumes. Our 2017 same-hospital inpatient and outpatient volumes were negatively impacted compared to the 2016 period by a leap-year day in the 2016 period and our out-of-network status with a national payer for most of the 2017 period. The 2016 period also included $112 million of net revenues from the California provider fee program compared to no revenues under the program in the 2017 period because CMS has not yet approved the 2017 program. Same-hospital net inpatient revenues decreased $81 million, or 1.5%, and same-hospital admissions decreased 2.8% in the six months ended June 30, 2017 compared to the same period in 2016. Same-hospital net inpatient revenue per admission increased 1.3%, primarily due to the improved terms of our managed care contracts in the six months ended

June 30, 2017 compared to the six months ended June 30, 2016. Same-hospital net outpatient revenues increased $58 million, or 2.0%, while same-hospital outpatient visits decreased 2.9% in the six months ended June 30, 2017 compared to the same period in 2016 due in part to the sale of home health and hospice assets. Growth in outpatient revenues was primarily driven by improved terms of our managed care contracts. Same-hospital net outpatient revenue per visit increased 5.1% in the six months ended June 30, 2017 compared to the six months ended June 30, 2016, primarily due to the improved terms of our managed care contracts and the sale of home health and hospice assets.

Provision for Doubtful Accounts

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.4% and 7.5% for the three months ended June 30, 2017 and 2016, respectively, and 8.5% and 7.6% for the six months ended June 30, 2017 and 2016, respectively. The increases in the 2017 periods compared to the 2016 periods were primarily driven by increases in uninsured revenues of $25 million and $72 million in the three month and six month periods, respectively.

The following table shows the consolidated net accounts receivable and allowance for doubtful accounts by payer at June 30, 2017 and December 31, 2016:

Table of Contents

	June 30, 2017			December 31, 2016		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$269	$ —	$269	$294	$ —	$294
Medicaid	109	—	109	125	—	125
Net cost report settlements payable and valuation allowances	(17)	—	(17)	(14)	—	(14)
Managed care	1,754	178	1,576	1,911	190	1,721
Self-pay uninsured	444	388	56	479	412	67
Self-pay balance after insurance	227	136	91	226	147	79
Estimated future recoveries	129	—	129	141	—	141
Other payers	538	218	320	537	239	298
Total Hospital Operations and other	3,453	920	2,533	3,699	988	2,711
Ambulatory Care	217	46	171	227	43	184
Total discontinued operations	2	—	2	2	—	2
	$3,672	$ 966	$2,706	$3,928	$ 1,031	$2,897

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At June 30, 2017, our Hospital Operations and other segment collection rate on self-pay accounts was approximately 25.6%. Our self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at June 30, 2017, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $7 million.

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated Hospital Operations and other segment collection rate from managed care payers was approximately 97.5% at June 30, 2017.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) AR Days and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations and other segment of $2.550 billion and $2.725 billion at June 30, 2017 and December 31, 2016, respectively, excluding cost report settlements payable and valuation allowances of $17 million and $14 million, respectively at June 30, 2017 and December 31, 2016:

	June 30, 2017									
	Medicare		Medicaid		Managed Care		Indemnity, Self-Pay and Other		Total	
0-60 days	93	%	72	%	65	%	28	%	60	%
61-120 days	4	%	15	%	13	%	14	%	12	%

121-180 days	1	%	6	%	7	%	9	%	7	%
Over 180 days	2	%	7	%	15	%	49	%	21	%
Total	100	%	100	%	100	%	100	%	100	%

	December 31, 2016									
	Medicare		Medicaid		Managed Care		Indemnity, Self-Pay and Other		Total	
0-60 days	92	%	75	%	61	%	24	%	60	%
61-120 days	5	%	15	%	15	%	14	%	13	%
121-180 days	2	%	4	%	8	%	10	%	6	%
Over 180 days	1	%	6	%	16	%	52	%	21	%
Total	100	%	100	%	100	%	100	%	100	%

Table of Contents