TENET HEALTHCARE CORP
Form 10-Q
November 03, 2014
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-Q

Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934
for the quarterly period ended September 30, 2014

OR

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

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

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

1445 Ross Avenue, Suite 1400
Dallas, TX 75202

(Address of principal executive offices, including zip code)

(469) 893-2200

(Registrant's telephone number, including area code)

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

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

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

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

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

As of October 31, 2014, there were 98,280,152 shares of the Registrant's common stock, $0.05 par value, outstanding.

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PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

Dollars in Millions

(Unaudited)

	September 30, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 200	$ 113
Accounts receivable, less allowance for doubtful accounts ($773 at September 30, 2014 and $589 at December 31, 2013)	2,238	1,890
Inventories of supplies, at cost	270	260
Income tax receivable	22	—
Current portion of deferred income taxes	725	692
Other current assets	746	737
Total current assets	4,201	3,692
Investments and other assets	366	357
Deferred income taxes, net of current portion	100	148
Property and equipment, at cost, less accumulated depreciation and amortization ($4,347 at September 30, 2014 and $3,907 at December 31, 2013)	7,749	7,582
Goodwill	3,705	3,566
Other intangible assets, at cost, less accumulated amortization ($623 at September 30, 2014 and $516 at December 31, 2013)	1,191	1,105
Total assets	$ 17,312	$ 16,450
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 98	$ 153
Accounts payable	1,068	1,085
Accrued compensation and benefits	735	622
Professional and general liability reserves	175	156
Accrued interest payable	265	198

Other current liabilities	804	879
Total current liabilities	3,145	3,093
Long-term debt, net of current portion	11,455	10,696
Professional and general liability reserves	525	555
Defined benefit plan obligations	381	398
Other long-term liabilities	544	490
Total liabilities	16,050	15,232
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	396	340
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 145,421,213 shares issued at September 30, 2014 and 144,057,351 shares issued at December 31, 2013	7	7
Additional paid-in capital	4,597	4,572
Accumulated other comprehensive loss	(20)	(24)
Accumulated deficit	(1,471)	(1,422)
Common stock in treasury, at cost, 47,196,935 shares at September 30, 2014 and 47,197,722 shares at December 31, 2013	(2,378)	(2,378)
Total shareholders' equity	735	755
Noncontrolling interests	131	123
Total equity	866	878
Total liabilities and equity	$ 17,312	$ 16,450

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

Dollars in Millions, Except Per-Share Amounts

(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues:				
Net operating revenues before provision for doubtful accounts	$ 4,428	$ 2,618	$ 13,096	$ 7,841
Less: Provision for doubtful accounts	249	210	949	624
Net operating revenues	4,179	2,408	12,147	7,217
Operating expenses:				
Salaries, wages and benefits	2,028	1,172	5,905	3,499
Supplies	665	387	1,942	1,158
Other operating expenses, net	1,032	575	3,066	1,710
Electronic health record incentives	(5)	(14)	(72)	(48)
Depreciation and amortization	207	119	609	354
Impairment and restructuring charges, and acquisition-related costs	37	20	90	45
Litigation and investigation costs	4	1	19	3
Operating income	211	148	588	496
Interest expense	(186)	(91)	(558)	(292)
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Investment earnings	—	—	—	1
Net income (loss) from continuing operations, before income taxes	1	57	6	(143)
Income tax benefit (expense)	18	(16)	11	57
Net income (loss) from continuing operations, before discontinued operations	19	41	17	(86)
Discontinued operations:				
Loss from operations	(2)	(8)	(17)	(5)
Litigation and investigation costs	—	(2)	(18)	(2)
Income tax benefit	1	5	13	3
Net loss from discontinued operations	(1)	(5)	(22)	(4)
Net income (loss)	18	36	(5)	(90)
Less: Net income attributable to noncontrolling interests	9	8	44	20
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ 9	$ 28	$ (49)	$ (110)

Amounts attributable to Tenet Healthcare Corporation common shareholders				
Net income (loss) from continuing operations, net of tax	$ 10	$ 33	$ (27)	$ (106)
Net loss from discontinued operations, net of tax	(1)	(5)	(22)	(4)
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ 9	$ 28	$ (49)	$ (110)
Earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders:				
Basic				
Continuing operations	$ 0.10	$ 0.33	$ (0.27)	$ (1.03)
Discontinued operations	(0.01)	(0.05)	(0.23)	(0.04)
	$ 0.09	$ 0.28	$ (0.50)	$ (1.07)
Diluted				
Continuing operations	$ 0.10	$ 0.32	$ (0.27)	$ (1.03)
Discontinued operations	(0.01)	(0.05)	(0.23)	(0.04)
	$ 0.09	$ 0.27	$ (0.50)	$ (1.07)
Weighted average shares and dilutive securities outstanding (in thousands):				
Basic	98,036	100,894	97,625	102,669
Diluted	100,926	103,098	97,625	102,669

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME

Dollars in Millions

(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net income (loss)	$ 18	$ 36	$ (5)	$ (90)
Other comprehensive income:				
Amortization of prior-year service costs included in net periodic benefit costs	1	—	4	—
Unrealized gains (losses) on securities held as available-for-sale	(1)	—	2	—
Other comprehensive income before income taxes	—	—	6	—
Income tax expense related to items of other comprehensive income	—	—	(2)	—
Total other comprehensive income, net of tax	—	—	4	—
Comprehensive net income (loss)	18	36	(1)	(90)
Less: Comprehensive income attributable to noncontrolling interests	9	8	44	20
Comprehensive net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ 9	$ 28	$ (45)	$ (110)

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

Dollars in Millions

(Unaudited)

	Nine Months Ended September 30,	
	2014	2013
Net loss	$ (5)	$ (90)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Depreciation and amortization	609	354
Provision for doubtful accounts	949	624
Deferred income tax benefit	(22)	(60)
Stock-based compensation expense	41	26
Impairment and restructuring charges, and acquisition-related costs	90	45
Litigation and investigation costs	19	3
Loss from early extinguishment of debt	24	348
Amortization of debt discount and debt issuance costs	21	12
Pre-tax loss from discontinued operations	35	7
Other items, net	(16)	(19)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(1,309)	(662)
Inventories and other current assets	12	(159)
Income taxes	(7)	(5)
Accounts payable, accrued expenses and other current liabilities	120	(44)
Other long-term liabilities	38	(5)
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	(115)	(36)
Net cash used in operating activities from discontinued operations, excluding income taxes	(16)	(5)
Net cash provided by operating activities	468	334
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(734)	(398)
Purchases of businesses or joint venture interests, net of cash acquired	(185)	(142)
Proceeds from sales of facilities and other assets — discontinued operations	4	11
Proceeds from sales of marketable securities, long-term investments and other assets	2	6
Other long-term assets	(4)	11
Other items, net	3	3
Net cash used in investing activities	(914)	(509)
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(1,965)	(1,001)
Proceeds from borrowings under credit facility	1,560	1,211

Repayments of other borrowings	(655)	(1,987)
Proceeds from other borrowings	1,608	1,907
Repurchases of common stock	—	(300)
Deferred debt issuance costs	(26)	(31)
Distributions paid to noncontrolling interests	(30)	(18)
Contributions from noncontrolling interests	15	98
Proceeds from exercise of stock options	23	22
Other items, net	3	(8)
Net cash provided by (used in) financing activities	533	(107)
Net increase (decrease) in cash and cash equivalents	87	(282)
Cash and cash equivalents at beginning of period	113	364
Cash and cash equivalents at end of period	$ 200	$ 82
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (487)	$ (295)
Income tax payments, net	$ (5)	$ (5)

See accompanying Notes to Condensed Consolidated Financial Statements.

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TENET HEALTHCARE CORPORATION

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a national, diversified healthcare services company. As of September 30, 2014, we operated 80 hospitals, 198 outpatient centers, six health plans and Conifer Health Solutions, LLC ("Conifer"), which provides healthcare business process services in the areas of revenue cycle management, value-based care and patient communications.

Effective October 1, 2013, we acquired the common stock of Vanguard Health Systems, Inc. ("Vanguard") for $21 per share in an all cash transaction. Vanguard owned and operated 28 hospitals (plus one more under construction, which was recently completed), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas. We paid approximately $4.3 billion to acquire Vanguard, including the assumption of $2.5 billion of Vanguard's net debt.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2013 ("Annual Report"). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). The accompanying Condensed Consolidated Balance Sheet as of December 31, 2013 was derived from the audited consolidated financial statements included in our Annual Report, but has been revised to reflect the impact of completing the purchase price allocation for the acquisition of Vanguard, as described in Note 14. Additionally, certain prior-year amounts have been adjusted to conform to the current-year presentation, including $73 million of Medicaid supplemental payments receivable that are now presented as other current assets rather than accounts receivable.

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

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

Operating results for the three and nine months ended September 30, 2014 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the number of covered lives managed by our health plans and the plans' ability to effectively manage medical costs; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and

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restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; any unfavorable publicity about us, which impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

Net Operating Revenues Before Provision for Doubtful Accounts

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

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
General Hospitals:				
Medicare	$ 838	$ 501	$ 2,560	$ 1,543
Medicaid	340	206	1,012	630
Managed care	2,369	1,378	6,787	4,126
Indemnity, self-pay and other	357	262	1,172	783
Acute care hospitals — other revenue	8	14	45	53
Other:				
Other operations	516	257	1,520	706
Net operating revenues before provision for doubtful accounts	$ 4,428	$ 2,618	$ 13,096	$ 7,841

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $200 million and $113 million at September 30, 2014 and December 31, 2013, respectively. As of September 30, 2014 and December 31, 2013, our book overdrafts were approximately $194 million and $245 million, respectively, which were classified as accounts payable.

At September 30, 2014 and December 31, 2013, approximately $98 million and $62 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries.

Also at September 30, 2014 and December 31, 2013, we had $113 million and $193 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $62 million and $138 million, respectively, were included in accounts payable.

During the nine months ended September 30, 2014 and 2013, we entered into non-cancellable capital leases of approximately $112 million and $99 million, respectively, primarily for buildings and equipment.

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Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets as of September 30, 2014 and December 31, 2013:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of September 30, 2014:			
Capitalized software costs	$ 1,326	$ (552)	$ 774
Long-term debt issuance costs	245	(42)	203
Trade names	106	—	106
Contracts	57	(5)	52
Other	80	(24)	56
Total	$ 1,814	$ (623)	$ 1,191

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
As of December 31, 2013:			
Capitalized software costs	$ 1,148	$ (468)	$ 680
Long-term debt issuance costs	230	(31)	199
Trade names	106	—	106
Contracts	57	(2)	55
Other	80	(15)	65
Total	$ 1,621	$ (516)	$ 1,105

Estimated future amortization of intangibles with finite useful lives as of September 30, 2014 is as follows:

		Years Ending December 31,					
	Total	2014	2015	2016	2017	2018	Later Years
Amortization of intangible assets	$ 1,077	$ 54	$ 190	$ 163	$ 134	$ 130	$ 406

NOTE 2. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

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

	September 30, 2014	December 31, 2013
Continuing operations:		
Patient accounts receivable	$ 2,978	$ 2,459
Allowance for doubtful accounts	(772)	(589)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	122	92
Net cost reports and settlements payable and valuation allowances	(92)	(75)
	2,236	1,887
Discontinued operations	2	3
Accounts receivable, net	$ 2,238	$ 1,890

As of September 30, 2014 and December 31, 2013, our allowance for doubtful accounts was 25.9% and 24.0%, respectively, of our patient accounts receivable. Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. As of September 30, 2014 and December 31, 2013, our allowance for doubtful accounts for self-pay was 79.5% and 75.9%, respectively, of our self-pay

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patient accounts receivable, including co-pays and deductibles owed by patients with insurance. As of September 30, 2014 and December 31, 2013, our allowance for doubtful accounts for managed care was 6.2% and 5.9%, respectively, of our managed care patient accounts receivable.

The estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the three months ended September 30, 2014 and 2013 were approximately $135 million and $116 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $488 million and $342 million, respectively. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the three months ended September 30, 2014 and 2013 were approximately $42 million and $32 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $137 million and $95 million, respectively. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the three months ended September 30, 2014 and 2013 were approximately $178 million and $72 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $493 million and $257 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels.

NOTE 3. DISCONTINUED OPERATIONS

Net operating revenues and loss before income taxes reported in discontinued operations are as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	$ 1	$ 3	$ 2	$ 6
Net loss before income taxes	(2)	(10)	(35)	(7)

Net loss before income taxes from discontinued operations in the nine months ended September 30, 2014 included approximately $18 million of expense recorded in litigation and investigation costs allocable to one of our previously divested hospitals related to a class action lawsuit discussed in Note 10. In the nine months ended September 30, 2013, we recognized a $7 million gain in discontinued operations related to the sale of land.

Should we dispose of additional hospitals or other assets in the future, we may incur asset impairment and restructuring charges in future periods.

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

During the nine months ended September 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $90 million, consisting of $14 million of employee severance costs, $6 million of contract and lease termination fees, $19 million of restructuring costs, and $51 million in acquisition-related costs, which include $7 million of transaction costs and $44 million of acquisition integration charges.

During the nine months ended September 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $45 million, consisting of $2 million relating to the impairment of property, $10 million of restructuring costs, $9 million of employee severance costs, $1 million in lease termination fees, and $23 million in acquisition-related costs.

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

As of September 30, 2014, our continuing operations consisted of two operating segments, our hospital and other operations and our Conifer subsidiary. During the three months ended March 31, 2014, we combined our

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California region and our Phoenix market to form our Western region. Our hospital and other operations are currently structured as follows:

- Our Central region includes all of our hospitals and other operations in Missouri, New Mexico, Tennessee and Texas, except for those in the Resolute Health, San Antonio and South Texas markets;
- Our Florida region includes all of our hospitals and other operations in Florida;
- Our Northeast region includes all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region includes all of our hospitals and other operations in Alabama, Georgia, North Carolina and South Carolina;
- Our Western region includes all of our hospitals and other operations in Arizona and California;
- Our Detroit market includes all of our hospitals and other operations in the Detroit, Michigan area;
- Our Resolute Health market includes our hospital and other operations in the New Braunfels, Texas area;
- Our San Antonio market includes all of our hospitals and other operations in the San Antonio, Texas area; and
- Our South Texas market includes all of our hospitals and other operations in the Brownsville and Harlingen, Texas areas.

These regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our hospital operations reportable business segment level.

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

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NOTE 5. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt as of September 30, 2014 and December 31, 2013:

	September 30, 2014	December 31, 2013
Senior notes:		
97/8%, due 2014	$ —	$ 60
91/4%, due 2015	—	474
5%, due 2019	1,100	—
51/ %, due 2019	500	—
63/4%, due 2020	300	300
8%, due 2020	750	750
81/8%, due 2022	2,800	2,800
67/8%, due 2031	430	430
Senior secured notes:		
61/4%, due 2018	1,041	1,041
43/4%, due 2020	500	500
6%, due 2020	1,800	1,800
41/2%, due 2021	850	850
43/8%, due 2021	1,050	1,050
Credit facility due 2016	—	405
Capital leases and mortgage notes	453	417
Unamortized note discounts and premium	(21)	(28)
Total long-term debt	11,553	10,849
Less current portion	98	153
Long-term debt, net of current portion	$ 11,455	$ 10,696

Credit Agreement

We have a senior secured revolving credit facility (as amended, “Credit Agreement”) that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement, which has a scheduled maturity date of November 29, 2016, is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals. In addition, borrowings under the Credit Agreement are guaranteed by our wholly owned hospital subsidiaries. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 1.00% to 1.50% or the London Interbank Offered Rate plus a margin ranging from 2.00% to 2.50% per annum based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.375% to 0.500% per annum

based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At September 30, 2014, we had no cash borrowings outstanding under the revolving credit facility; however, we had approximately $6 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $994 million was available for borrowing under the revolving credit facility at September 30, 2014.

Letter of Credit Facility

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

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Drawings under any letter of credit issued under the LC Facility (including the Existing Letters of Credit) that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.875% per annum. An unused commitment fee is payable at an initial rate of 0.50% per annum with a step down to 0.375% per annum based on the secured debt to EBITDA ratio of 3.00 to 1.00. A per annum fee on the aggregate outstanding amount of issued but undrawn letters of credit (including Existing Letters of Credit) will accrue at a rate of 1.875% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At September 30, 2014, we had approximately $115 million of standby letters of credit outstanding under the LC Facility.

Senior Notes

In September 2014, we sold $500 million aggregate principal amount of 5$^{1}/_{2}$% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, commencing on March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 91/4% senior notes due 2015 in July 2014. In connection with the redemption, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the notes, as well as the write-off of associated unamortized note discounts and issuance costs. The net proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement.

All of our senior notes are general unsecured senior debt obligations that rank equally in right of payment with all of our other unsecured senior indebtedness, but are effectively subordinated to our senior secured notes described in our Annual Report, the obligations of our subsidiaries, and any obligations under our Credit Agreement and the LC Facility to the extent of the collateral. Our Annual Report also describes the covenants and conditions, as well as other provisions, including our redemption rights, set forth in the indentures governing our senior notes.

NOTE 6. GUARANTEES

At September 30, 2014, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $92 million. We had a liability of $69 million recorded for these guarantees

included in other current liabilities at September 30, 2014.

NOTE 7. EMPLOYEE BENEFIT PLANS

At September 30, 2014, approximately 5.2 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, from time to time, we grant (i) options and restricted stock units with different time-based vesting terms, and (ii) performance-based options and restricted stock units that vest subject to the achievement of specified performance goals within a specified timeframe.

Our income from continuing operations for the nine months ended September 30, 2014 and 2013 includes $38 million and $29 million, respectively, of pre-tax compensation costs related to our stock-based compensation arrangements recorded in salaries, wages and benefits in the accompanying Condensed Consolidated Statements of Operations.

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Stock Options

The following table summarizes stock option activity during the nine months ended September 30, 2014:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding as of December 31, 2013	3,308,111	$ 30.79		
Granted	—			
Exercised	(691,050)	33.72		
Forfeited/Expired	(624,052)	47.97		
Outstanding as of September 30, 2014	1,993,009	$ 24.40	$ 70	3.9 years
Vested and expected to vest at September 30, 2014	1,984,562	$ 24.31	$ 70	3.9 years
Exercisable as of September 30, 2014	1,587,878	$ 21.90	$ 60	3.7 years

There were 691,050 stock options exercised during the nine months ended September 30, 2014 with a $13 million aggregate intrinsic value, and 913,369 stock options exercised during the same period in 2013 with a $17 million aggregate intrinsic value.

As of September 30, 2014, there were $2 million of total unrecognized compensation costs related to stock options. These costs are expected to be recognized over a weighted average period of 1.1 years.

There were no stock options granted in the nine months ended September 30, 2014. In the nine months ended September 30, 2013, we granted an aggregate of 295,639 stock options under our 2008 Stock Incentive Plan to certain of our senior officers. These stock options will all vest on the third anniversary of the grant date, subject to the terms of the Plan, and will expire on the fifth anniversary of the grant date.

The weighted average estimated fair value of stock options we granted in the nine months ended September 30, 2013 was $14.46 per share. This fair value was calculated based on the grant date, using a binomial lattice model with the following assumptions:

	Nine Months Ended September 30, 2013
Expected volatility	50%
Expected dividend yield	0%
Expected life	3.6 years
Expected forfeiture rate	6%
Risk-free interest rate	0.48%
Early exercise threshold	100% gain
Early exercise rate	50% per year

The expected volatility used in the binomial lattice model incorporated historical and implied share-price volatility and was based on an analysis of historical prices of our stock and open-market exchanged options. The expected volatility reflects the historical volatility for a duration consistent with the contractual life of the options, and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The historical share-price volatility excludes the movements in our stock price on two dates (one in 2010 and one in 2011) with unusual volatility due to an unsolicited acquisition proposal. The expected life of options granted is derived from the output of the binomial lattice model and represents the period of time that the options are expected to be outstanding. This model incorporates an early exercise assumption in the event of a significant increase in stock price. The risk-free interest rates are based on zero-coupon United States Treasury yields in effect at the date of grant consistent with the expected exercise timeframes.

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The following table summarizes information about our outstanding stock options at September 30, 2014:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	242,753	4.4 years	$ 4.56	242,753	$ 4.56
$4.57 to $25.089	957,583	5.2 years	20.96	830,903	20.67
$25.09 to $32.569	402,816	1.9 years	29.32	402,816	29.32
$32.57 to $42.089	389,857	2.5 years	40.10	111,406	42.08
	1,993,009	3.9 years	$ 24.40	1,587,878	$ 21.90

Restricted Stock Units

The following table summarizes restricted stock unit activity during the nine months ended September 30, 2014:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested as of December 31, 2013	2,707,222	$ 33.34
Granted	1,768,508	48.41
Vested	(900,763)	36.51
Forfeited	(140,468)	35.23
Unvested as of September 30, 2014	3,434,499	$ 41.85

In the nine months ended September 30, 2014, we granted 1,045,750 restricted stock units subject to time-vesting of which 944,249 will vest and be settled ratably over a three-year period from the date of the grant, 23,435 will vest 100% on the tenth anniversary of the grant date, 63,623 will vest 100% on the fifth anniversary of the grant date and 14,443 will vest 100% on the third anniversary of the grant date. In addition, we granted 271,815 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of a specified one-year performance goal for the year ending December 31, 2014. Provided the goal is achieved, the performance-based restricted stock units will vest ratably over a three-year period from the grant date. If the performance goal is not achieved, the restricted stock units will be forfeited. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 271,815 units granted, depending on our level of achievement with respect to the performance goal. We also granted 450,943 special retention restricted stock units to a select group of officers; two-thirds of the award will vest contingent on our

achievement of a performance goal of which one-half will vest based on performance over a one-year period ending in December 2015 and the remaining one-half will vest based on performance over a four-year period ending in December 2018. The remaining one-third of this special retention award will vest in full on the fifth anniversary of the grant date.

In the nine months ended September 30, 2013, we granted 815,262 restricted stock units subject to time-vesting, of which 735,129 will vest and be settled ratably over a three-year period from the grant date and 80,133 will vest 100% on the fifth anniversary of the grant date. In addition, we granted 206,058 performance-based restricted stock units to certain of our senior officers. Because the performance goal for the year ended December 31, 2013 was met at the target level, 100% of the performance-based restricted stock units will vest and be settled ratably over a three-year period from the grant date. We also awarded a grant of 212,180 restricted stock units to our chief executive officer, of which 106,090 are subject to time-vesting and 106,090 are performance-based. If target conditions are met, 50% of this grant will vest three years from the grant date and the remaining 50% will vest six years from the grant date. The award also allows for an additional 106,090 shares to be issued if higher performance criteria are met.

As of September 30, 2014, there were $107 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 3.0 years.

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NOTE 8. EQUITY

Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the nine months ended September 30, 2014 and 2013 (dollars in millions, share amounts in thousands):

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock							
	Shares Outstanding	Issued Par Amount	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
Balances at December 31, 2013	96,860	$ 7	$ 4,572	$ (24)	$ (1,422)	$ (2,378)	$ 123	$ 878
Net income (loss)	—	—	—	—	(49)	—	20	(29)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(27)	(27)
Contributions from noncontrolling interests	—	—	—	—	—	—	5	5
Other comprehensive income	—	—	—	4	—	—	—	4
Purchases (sales) of businesses or joint venture interests	—	—	(22)	—	—	—	10	(12)
Stock-based compensation expense and issuance of common stock	1,364	—	47	—	—	—	—	47
	98,224	$ 7	$ 4,597	$ (20)	$ (1,471)	$ (2,378)	$ 131	$ 866

Balances at September 30, 2014								
Balances at December 31, 2012	104,633	$ 7	$ 4,471	$ (68)	$ (1,288)	$ (1,979)	$ 75	$ 1,218
Net income (loss)	—	—	—	—	(110)	—	13	(97)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(16)	(16)
Sales of joint venture interests	—	—	53	—	—	—	—	53
Purchases of businesses or joint venture interests	—	—	—	—	—	—	23	23
Repurchase of common stock	(7,095)	—	—	—	—	(300)	—	(300)
Stock-based compensation expense and issuance of common stock	1,628	—	38	—	—	1	—	39
Balances at September 30, 2013	99,166	$ 7	$ 4,562	$ (68)	$ (1,398)	$ (2,278)	$ 95	$ 920

Changes in Redeemable Noncontrolling Interests in Equity of Consolidated Subsidiaries

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the nine months ended September 30, 2014 and 2013:

	Nine Months Ended September 30,	
	2014	2013
Balances at beginning of period	$ 340	$ 16
Net income	24	7
Distributions paid to noncontrolling interests	(3)	(2)
Contributions from noncontrolling interests	10	—
Sales of joint venture interests	—	52

Purchases of businesses	25	10
Balances at end of period	$ 396	$ 83

NOTE 9. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

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

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Professional and General Liability Reserves

At September 30, 2014 and December 31, 2013, the aggregate current and long-term professional and general liability reserves in our accompanying Condensed Consolidated Balance Sheets were approximately $700 million and $711 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on actuarial estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 2.22% at September 30, 2014 and 2.45% at December 31, 2013.

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

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $170 million and $71 million for the nine months ended September 30, 2014 and 2013, respectively.

NOTE 10. CLAIMS AND LAWSUITS

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

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

Governmental Reviews

Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. Certain of our individual facilities have received inquiries from government agencies, and our facilities may receive such inquiries in future periods. The following material governmental reviews, which have been previously reported, are currently pending.

- Kyphoplasty—From March 2009 through July 2010, seven of our hospitals became the subject of a review by the U.S. Department of Justice ("DOJ") and certain other federal agencies regarding the appropriateness of inpatient treatment for Medicare patients receiving kyphoplasty, which is a surgical procedure used to treat certain spinal conditions. In January 2013, we paid $900,000 to settle claims against one of our hospitals subject to this review, and, in April 2014, we confirmed that another hospital is no longer the subject of investigation. In September 2014, subject to negotiation of final settlement terms, we reached a verbal financial agreement with the government to settle this matter with respect to the remaining five hospitals for approximately $2 million, which has been fully reserved as of September 30, 2014.

- Implantable Cardioverter Defibrillators ("ICDs")—We are engaged in potential settlement discussions with the DOJ to resolve an investigation to determine whether ICD procedures performed at 56 of our hospitals from 2002 to 2010 complied with Medicare coverage requirements. It is impossible at this time to predict with any certainty the outcome of those discussions or the amount of any potential resolution. However, based on current discussions, we believe the amount of the reserve management has established for this matter, as described below, continues to reflect our current estimate of probable liability for all of the hospitals under review as part of the government's examination, which commenced in March 2010.

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- Clinica de la Mama Investigations and Qui Tam Action—As previously reported, we received a subpoena in May 2012 from the Office of Inspector General ("OIG") of U.S. Department of Health and Human Services in Atlanta seeking documents from January 2004 through May 2012 related to the relationship that certain of our Georgia and South Carolina hospitals had with Hispanic Medical Management, Inc. ("HMM"). HMM was an unaffiliated entity that owned and operated clinics that provided, among other things, prenatal care predominantly to uninsured patients. The hospitals contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. The civil investigation is being conducted by the Civil Division of the DOJ, the U.S. Attorney's Office for the Middle District of Georgia and the Georgia Attorney General's Office, while the parallel criminal investigation is being conducted by the Criminal Division of the DOJ and the U.S. Attorney's Office for the Northern District of Georgia.

The investigations arose out of a qui tam action captioned United States of America, ex. rel. Ralph D. Williams v. Health Management Associates, Inc., et al. filed in the U.S. District Court for the Middle District of Georgia. Tenet and four of its hospital subsidiaries are defendants in the qui tam action, which alleges that the arrangements the hospitals had with HMM violated the federal and state anti-kickback statutes and false claims acts. Both the Georgia Attorney General's Office, on behalf of the State of Georgia, and the U.S. Attorney's Office, on behalf of the United States, have intervened in the qui tam action. We submitted answers to the complaints filed by the relator, the State of Georgia and the United States on July 15, 2014 following the court's denial of our motions to dismiss in June 2014. The parties have agreed to stay discovery in the case until March 31, 2015.

If we or our subsidiaries were determined to have violated the anti-kickback statutes, the government could require us to reimburse related government program payments received during the subject period, assess civil monetary penalties including treble damages, exclude individuals or subsidiaries from participation in federal healthcare programs, or seek criminal sanctions against current or former employees of our hospital subsidiary companies or the hospital companies themselves. In a Bill of Information filed on July 23, 2014 with the U.S. District Court for the Northern District of Georgia, Atlanta Division, the U.S. Attorney for that District asserted charges of one count of criminal conspiracy against a former owner of HMM (a non-employee of Tenet) related to the agreements between HMM and the Tenet hospitals described above. In a separate Bill of Information also filed with the court on July 23, 2014, the U.S. Attorney asserted charges of one count of criminal conspiracy against a former employee of a Tenet hospital, but such charges relate to an unaffiliated entity. It is impossible at this time to predict with any certainty the amount and terms of any potential resolution of these matters; however, we believe the amount of the reserve established continues to reflect our current estimate of probable liability. We will continue to vigorously defend against the government's allegations.

Except with respect to the matter settled in January 2013 involving one hospital, as discussed above, our analysis of each of these pending reviews is still ongoing, and we are unable to predict with any certainty the progress or final outcome of any discussions with government agencies at this time. Management has established reserves of approximately $38 million in the aggregate for our potential obligations with respect to all of the hospitals under review for their billing practices for kyphoplasty and cardiac defibrillator implantation procedures, as well as the Clinica de la Mama matters. Changes in the reserves may be required in the future as additional information becomes available. We cannot predict the ultimate resolution of any governmental review, and the final amounts paid in settlement or otherwise, if any, could differ materially from our currently recorded reserves.

Ordinary Course Matters

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

In addition, in October 2014, we received court approval of a final agreement to settle a previously disclosed class action lawsuit captioned Doe, et al. v. Jo Ellen Smith Medical Foundation, which was filed in the Civil District

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Court for the Parish of Orleans in Louisiana in March 1997. The plaintiffs pursued a claim for tortious invasion of privacy due to the fact that in April 1996 patient identifying records from a psychiatric hospital we closed in 1995 were temporarily placed in an unsecure location while the hospital was undergoing renovations. The court certified a class of over 5,000 persons; however, only eight individuals (in addition to the two plaintiffs) have been identified to date in the class certification process. The plaintiffs have asserted each member of the class is entitled to common damages under a theory of presumed "common damage" regardless of whether or not any members of the class were actually harmed or even aware of the incident. In an effort to avoid protracted litigation, the parties settled this matter in June 2014 for a maximum potential payment of $32.5 million, subject to the number and type of claims asserted by the class members between January 15 and March 31, 2015. The settlement will be funded in amounts and on a schedule to be agreed to by the parties. In the three months ended June 30, 2014, we established a reserve of $17 million, recorded in discontinued operations, to reflect our current estimate of probable liability for this matter based on anticipated levels of class member participation.

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

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the nine months ended September 30, 2014 and 2013:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Balances at End of Period
Nine Months Ended September 30, 2014				
Continuing operations	$ 64	$ 19	$ (10)	$ 73
Discontinued operations	6	18	(6)	18
	$ 70	$ 37	$ (16)	$ 91
Nine Months Ended September 30, 2013				
Continuing operations	$ 5	$ 3	$ (3)	$ 5
Discontinued operations	5	2	(1)	6
	$ 10	$ 5	$ (4)	$ 11

For the nine months ended September 30, 2014 and 2013, we recorded costs of $37 million and $5 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

NOTE 11. INCOME TAXES

During the nine months ended September 30, 2014, we recorded a net income tax benefit of $11 million, which includes, among other things: (1) $3 million of income tax expense to increase our valuation allowance for deferred tax assets; (2) $7 million of income tax benefit related to tax basis adjustments for state tax purposes on the Vanguard acquisition; (3) $4 million of income tax benefit related to certain amended state tax returns; and (4) $4 million of income tax benefit related to other tax adjustments. The increase in the valuation allowance relates to an estimated decrease in the future utilization of certain state net operating loss carryovers.

During the nine months ended September 30, 2014, we reduced our estimated liabilities for uncertain tax positions by $3 million, net of related deferred tax assets. The total amount of unrecognized tax benefits as of September 30, 2014 was $40 million, of which $31 million, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. Total accrued interest and penalties on unrecognized tax benefits as of September 30, 2014 were $5 million, all of which related to continuing operations.

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As of September 30, 2014, approximately $2 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

NOTE 12. EARNINGS (LOSS) PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for net income (loss) from continuing operations for the three and nine months ended September 30, 2014 and 2013. Net income (loss) is expressed in millions and weighted average shares are expressed in thousands.

	Net Income (Loss) (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended September 30, 2014			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 10	98,036	$ 0.10
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,890	—
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	$ 10	100,926	$ 0.10
Three Months Ended September 30, 2013			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 33	100,894	$ 0.33
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,204	(0.01)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	$ 33	103,098	$ 0.32
Nine Months Ended September 30, 2014			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (27)	97,625	$ (0.27)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	$ (27)	97,625	$ (0.27)
Nine Months Ended September 30, 2013			

Net loss attributable to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ (106)	102,669	$ (1.03)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted earnings per share	$ (106)	102,669	$ (1.03)

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the nine months ended September 30, 2014 and 2013 because we did not report income from continuing operations available to shareholders in those periods. In circumstances where we do not have income from continuing operations available to shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations available to shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to shareholders in those periods, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase in shares of 2,332 for the nine months ended September 30, 2014 and 827 for the nine months ended September 30, 2013.

NOTE 13. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis as of September 30, 2014 and December 31, 2013. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active

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market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

Investments	September 30, 2014	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable securities — current	$ 2	$ 2	$ —	$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
Marketable debt securities — noncurrent	62	26	35	1
	$ 66	$ 28	$ 37	$ 1

Investments	December 31, 2013	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable securities — current	$ 1	$ 1	$ —	$ —
Investments in Reserve Yield Plus Fund	2	—	2	—
Marketable debt securities — noncurrent	62	23	38	1
	$ 65	$ 24	$ 40	$ 1

The fair value of our long-term debt is based on quoted market prices (Level 1). At September 30, 2014 and December 31, 2013, the estimated fair value of our long-term debt was approximately 103.8% and 103.5%, respectively, of the carrying value of the debt.

NOTE 14. ACQUISITIONS

During the nine months ended September 30, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles

southeast of San Francisco. We also acquired four ambulatory surgery centers, three urgent care centers, one diagnostic imaging center and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions (the “purchase price”) was $185 million.

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

Preliminary purchase price allocations for the acquisitions made during the nine months ended September 30, 2014 are as follows:

Current assets	$ 19
Property and equipment	104
Goodwill	137
Current liabilities	(21)
Long-term liabilities	(19)
Redeemable noncontrolling interests	(21)
Noncontrolling interests	(14)
Net cash paid	$ 185

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The goodwill generated from these transactions, the majority of which will be deductible for income tax purposes, can be attributed to the benefits that we expect to realize from operating efficiencies and increased reimbursement. Approximately $7 million in transaction costs related to prospective and closed acquisitions were expensed during the nine months ended September 30, 2014, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statement of Operations.

Acquisition of Vanguard

Effective October 1, 2013, we acquired the common stock of Vanguard for $21 per share in an all cash transaction. Vanguard owned and operated 28 hospitals (plus one more under construction, which was recently completed), 39 outpatient centers and five health plans with approximately 140,000 members, serving communities in Arizona, California, Illinois, Massachusetts, Michigan and Texas. We paid approximately $4.3 billion to acquire Vanguard, including the assumption of $2.5 billion of Vanguard's net debt. We have completed the analysis required to finalize the purchase price allocation for this acquisition and related disclosures. We have revised our Condensed Consolidated Balance Sheet as of December 31, 2013 to reflect the impact of these adjustments.

The purchase price allocation for our Vanguard acquisition is as follows:

Current assets	$ 976
Property and equipment	2,830
Other long term assets	152
Other intangible assets	155
Goodwill	2,460
Current liabilities	(1,193)
Deferred taxes-long term	(103)
Other long-term liabilities	(3,711)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(258)
Noncontrolling interests	(7)
Net cash paid	$ 1,301

Pro Forma Information—Unaudited

The following table provides certain pro forma financial information for Tenet as if the Vanguard acquisition had occurred at the beginning of the year ended December 31, 2013:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	$ 4,179	$ 3,748	$ 12,147	$ 11,574
Net income (loss) from continuing operations, before income taxes	$ 1	$ (220)	$ 6	$ (418)

NOTE 15. SEGMENT INFORMATION

Our core business is hospital operations and other, which is focused on owning and operating acute care hospitals and outpatient facilities. We also own various related healthcare businesses. At September 30, 2014, our subsidiaries operated 80 hospitals, with a total of 20,762 licensed beds, primarily serving urban and suburban communities, as well as 198 outpatient centers and six health plans.

We operate revenue cycle management and patient communications and engagement services businesses under our Conifer subsidiary. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. At September 30, 2014, Conifer provided services to more than 700 Tenet and non-Tenet hospital and other clients

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nationwide. Conifer's two largest customers, Tenet and Catholic Health Initiatives, together comprised 82% and 78% of Conifer's net operating revenues for the nine months ended September 30, 2014 and 2013, respectively.

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

	September 30, 2014	December 31, 2013
Assets:		
Hospital operations and other	$ 16,988	$ 16,194
Conifer	324	256
Total	$ 17,312	$ 16,450

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Capital expenditures:				
Hospital operations and other	$ 207	$ 139	$ 717	$ 387
Conifer	4	3	17	11
Total	$ 211	$ 142	$ 734	$ 398
Net operating revenues:				
Hospital operations and other	$ 4,031	$ 2,275	$ 11,707	$ 6,840
Conifer				
Tenet	148	92	426	278
Other customers	148	133	440	377
	4,327	2,500	12,573	7,495
Intercompany eliminations	(148)	(92)	(426)	(278)
Total	$ 4,179	$ 2,408	$ 12,147	$ 7,217
Adjusted EBITDA:				
Hospital operations and other	$ 412	$ 252	$ 1,167	$ 802
Conifer	47	36	139	96
Total	$ 459	$ 288	$ 1,306	$ 898
Depreciation and amortization:				
Hospital operations and other	$ 202	$ 114	$ 594	$ 339

Conifer	5	5	15	15
Total	$ 207	$ 119	$ 609	$ 354
Adjusted EBITDA	$ 459	$ 288	$ 1,306	$ 898
Depreciation and amortization	(207)	(119)	(609)	(354)
Impairment and restructuring charges, and acquisition-related costs	(37)	(20)	(90)	(45)
Litigation and investigation costs	(4)	(1)	(19)	(3)
Interest expense	(186)	(91)	(558)	(292)
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Investment earnings	—	—	—	1
Net income (loss) from continuing operations before income taxes	$ 1	$ 57	$ 6	$ (143)

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NOTE 16. RECENTLY ISSUED ACCOUNTING STANDARDS

In April 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-08, "Presentation of Financial Statements (Topic 205) and Property, Plant, and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity" ("ASU 2014-08"). ASU 2014-08 changes the requirements for reporting discontinued operations in FASB Accounting Standards Codification Subtopic 205-20, such that a disposal of a component of an entity or a group of components of an entity is required to be reported in discontinued operations if the disposal represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. ASU 2014-08 requires an entity to present, for each comparative period, the assets and liabilities of a disposal group that includes a discontinued operation separately in the asset and liability sections, respectively, of the statement of financial position, as well as additional disclosures about discontinued operations. Additionally, ASU 2014-08 requires disclosures about a disposal of an individually significant component of an entity that does not qualify for discontinued operations presentation in the financial statements and expands the disclosures about an entity's significant continuing involvement with a discontinued operation. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2015.

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2017.

NOTE 17. SUBSEQUENT EVENTS

Acquisition of Revenue Cycle Services for Physician Practices—In October 2014, Conifer acquired SPi Healthcare, a provider of revenue cycle management, health information management and software solutions for independent and provider-owned physician practices. The base purchase price was $235 million. We have not yet finalized the analysis required to complete the purchase price allocation for this acquisition and the related disclosures.

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is hospital operations and other, which is focused on owning and operating acute care hospitals and outpatient facilities. We also operate revenue cycle management, patient communications and engagement services, and management services businesses through our Conifer Health Solutions, LLC ("Conifer") subsidiary, which is a separate reportable business segment. MD&A, which should be read in conjunction with the accompanying Condensed Consolidated Financial Statements, includes the following sections:

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

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted patient admission, per patient day, per adjusted patient day and per visit amounts). Continuing operations information includes the results of (i) our same-hospital operations, as described below, (ii) Vanguard Health Systems, Inc. ("Vanguard") and its consolidated subsidiaries, which we acquired effective October 1, 2013, but only for the three and nine months ended September 30, 2014, and (iii) Resolute Health Hospital, a newly constructed facility opened in June 2014, Texas Regional Medical Center at Sunnyvale, in which we acquired a majority interest in June 2014, and Emanuel Medical Center, which we acquired in August 2014, in each case only for the period of time from such opening or acquisition to September 30, 2014. Continuing operations information excludes the results of our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. Same-hospital information includes the results of our operations for all periods presented, including the same 49 hospitals operated during the three and nine months ended September 30, 2014 and 2013, but excludes the results of (i) legacy Vanguard operations, (ii) Resolute Health Hospital, Texas Regional Medical Center and Emanuel Medical Center, and (iii) our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. We present same-hospital data because we believe it provides investors with useful information regarding the performance of our hospitals and other operations that are comparable for the periods presented.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Acquisition of Revenue Cycle Services for Physician Practices—In October 2014, Conifer acquired SPi Healthcare, a provider of revenue cycle management, health information management and software solutions for independent and provider-owned physician practices. We believe the combined organization will drive incremental growth for Conifer in the physician revenue cycle marketplace.

STRATEGIES AND TRENDS

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

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Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to healthcare providers through Conifer. With respect to our hospitals and outpatient business, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology to remain competitive, to recruit and retain physicians, to increase the number of outpatient centers we own, and to negotiate favorable contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, our management services offerings have expanded to support value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We have made significant investments in the last decade in equipment, technology, education and operational strategies designed to improve clinical quality at our hospitals and outpatient centers. As a result of our efforts, our Hospital Compare Core Measures scores from the Centers for Medicare and Medicaid Services (“CMS”) have consistently exceeded the national average since the end of 2005, and major national private payers have also recognized our achievements relative to quality. These designations are expected to become increasingly important as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others. Through our Commitment to Quality and Performance Excellence Program initiatives, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay, as well as reductions in redundant ancillary services and readmissions for hospitalized patients. In general, we believe that quality of care improvements may have the effect of reducing costs, increasing payments from Medicare and certain managed care payers for our services, and increasing physician and patient satisfaction, which may improve our volumes.

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

From time to time, we build new facilities, make strategic acquisitions of healthcare assets and companies, and enter into joint venture arrangements or affiliations with healthcare businesses in markets where we believe our operating strategies can improve performance and create shareholder value. Most recently, we purchased Emanuel Medical Center, a 209-bed hospital located in Northern California, we opened a newly constructed 128-bed hospital and wellness campus in New Braunfels, Texas, and we acquired a majority interest in a 70-bed regional medical center in a suburban community east of Dallas. In addition, in May 2014, we announced a joint venture with Texas Tech University Health Sciences Center at El Paso to develop and build a new 140-bed teaching hospital and a medical office building in west El Paso, Texas. In the nine months ended September 30, 2014, we also acquired four ambulatory surgery centers, three urgent care centers, one diagnostic imaging center and various physician practice entities.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the nine months ended September 30, 2014, we derived approximately 37% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. We believe that growth by strategic acquisitions, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. In addition, we expect that our new national MedPost brand will assist us in growing our urgent care business as part of our broader strategy to offer more services to patients and to expand into faster-growing, less capital intensive, higher-margin businesses. Furthermore, we continually evaluate collaboration opportunities with outpatient facilities, healthcare providers, physician groups and others in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

We intend to continue expanding Conifer's revenue cycle management, patient communications and engagement services, and management services businesses by marketing these services to non-Tenet hospitals and other healthcare-related entities. Conifer provides services to more than 700 Tenet and non-Tenet hospital and other clients nationwide. We believe this business has the potential over time to generate high margins and improve our results of

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operations. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals, clients for these services include health plans, self-insured employers and other entities. In October 2014, Conifer acquired SPi Healthcare, which is expected to drive Conifer's incremental growth in the areas of revenue cycle management, health information management and software solutions services for independent and provider-owned physician practices.

Realizing HIT Incentive Payments and Other Benefits—Beginning in the year ended December 31, 2011, we began achieving compliance with certain of the health information technology ("HIT") requirements under the American Recovery and Reinvestment Act of 2009 ("ARRA"). In 2013, we recognized approximately $96 million of Medicare electronic health record ("EHR") and Medicaid ARRA HIT incentives. During the nine months ended September 30, 2014, we recognized approximately $72 million of Medicare and Medicaid EHR ARRA incentives. These incentives partially offset the operating expenses and capital costs we have incurred and continue to incur to invest in HIT systems. We expect to recognize additional incentives in the future. Furthermore, we believe that the operational benefits of HIT, including improved clinical outcomes and increased operating efficiencies, will contribute to our long-term ability to grow our business.

General Economic Conditions—We believe that high unemployment rates in some of the markets our hospitals serve and other adverse economic conditions are continuing to have a negative impact on our bad debt expense levels and payer mix. However, as the economy recovers, we expect to experience improvements in these metrics relative to current levels. We believe our volumes were positively impacted in the nine months ended September 30, 2014 by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. We believe our patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher patient co-pays and deductibles, and demographic trends. We continue to pursue integrated contracting models that maximize our system-wide skills and capabilities in conjunction with our strong market positions to accommodate new payment models. In several markets, we have formed clinical integration organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. For example, in January 2014, our Abrazo Health network of hospitals in the Phoenix, Arizona area entered into a joint venture with Dignity Health to fund and expand the Arizona Care Network, a physician-led, physician-governed ACO and clinically integrated network focused on improved quality through shared resources, advanced technology and clinical best practices that align with emerging models of care delivery. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of Affordable Care Act—We anticipate that we will benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") that have begun to extend insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by governmental payers, we began to receive reimbursement for caring for previously uninsured and underinsured patients in 2014. Through collaborative efforts with local community organizations, we have launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans. Effective January 1, 2014, four of the states in which we operate (Arizona, California, Illinois and Massachusetts) expanded their Medicaid programs under the ACA. A fifth state (Michigan) expanded its Medicaid program effective April 1, 2014.

Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is critical that we continue to make steady and measurable progress in 2014 in successfully integrating Vanguard's business and operations

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into our business processes. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report and the Risk Factors section in Part II of this report.

RESULTS OF OPERATIONS—OVERVIEW

Selected Operating Statistics for All Continuing Operations Hospitals—The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014, in each case only for the period of time from such acquisition or opening to September 30, 2014. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase in the scale of our operations as a result of these investments.

	Total Hospital Continuing Operations Three Months Ended September 30,		
	2014	2013	Increase (Decrease)
Total admissions	199,914	121,569	64.4 %
Adjusted patient admissions(1)	345,787	196,761	75.7 %
Paying admissions (excludes charity and uninsured)	188,924	112,760	67.5 %
Charity and uninsured admissions	10,990	8,809	24.8 %
Admissions through emergency department	123,147	75,512	63.1 %
Emergency department visits	719,835	400,345	79.8 %
Total emergency department admissions and visits	842,982	475,857	77.2 %
Surgeries — inpatient	55,339	34,971	58.2 %
Surgeries — outpatient	123,100	76,084	61.8 %
Total surgeries	178,439	111,055	60.7 %
Patient days — total	921,228	569,833	61.7 %
Adjusted patient days(1)	1,574,346	912,483	72.5 %
Average length of stay (days)	4.61	4.69	(1.7) %
Average licensed beds	20,692	13,180	57.0 %
Utilization of licensed beds(2)	48.4 %	47.0 %	1.4 %(3)
Total visits	2,125,002	1,071,421	98.3 %
Paying visits (excludes charity and uninsured)	1,954,980	956,871	104.3 %
Charity and uninsured visits	170,022	114,550	48.4 %
Net inpatient revenues	$ 2,463	$ 1,502	64.0 %
Net outpatient revenues	$ 1,441	$ 845	70.5 %
Net inpatient revenue per admission	$ 12,320	$ 12,355	(0.3) %

Net inpatient revenue per patient day	$ 2,674	$ 2,636	1.4 %
Net outpatient revenue per visit	$ 678	$ 789	(14.1) %
Net patient revenue per adjusted patient admission(1)	$ 11,290	$ 11,928	(5.3) %
Net patient revenue per adjusted patient day(1)	$ 2,480	$ 2,572	(3.6) %

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

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

(3) The change is the difference between the amounts shown for the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Operating Statistics on a Same-Hospital Basis—Our results of operations have been and continue to be influenced by industry-wide and company-specific challenges, including constrained volume growth and high levels of bad debt, that have affected our revenue growth and operating expenses. We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended September 30, 2014 and 2013 on a same-hospital basis, where noted, excluding the results of the 28 hospitals we acquired from Vanguard on

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October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014.

	Same-Hospital Continuing Operations Three Months Ended September 30,					
Admissions, Patient Days and Surgeries	2014		2013		Increase (Decrease)	
Total admissions	127,118		121,569		4.6	%
Adjusted patient admissions(1)	208,229		196,761		5.8	%
Paying admissions (excludes charity and uninsured)	118,580		112,760		5.2	%
Charity and uninsured admissions	8,538		8,809		(3.1)	%
Admissions through emergency department	80,328		75,512		6.4	%
Paying admissions as a percentage of total admissions	93.3	%	92.8	%	0.5	%(2)
Charity and uninsured admissions as a percentage of total admissions	6.7	%	7.2	%	(0.5)	%(2)
Emergency department admissions as a percentage of total admissions	63.2	%	62.1	%	1.1	%(2)
Surgeries — inpatient	35,570		34,971		1.7	%
Surgeries — outpatient	91,472		76,084		20.2	%
Total surgeries	127,042		111,055		14.4	%
Patient days — total	594,664		569,833		4.4	%
Adjusted patient days(1)	962,054		912,483		5.4	%
Average length of stay (days)	4.68		4.69		(0.2)	%
Number of acute care hospitals (at end of period)	49		49		—	
Licensed beds (at end of period)	13,231		13,180		0.4	%
Average licensed beds	13,231		13,180		0.4	%
Utilization of licensed beds(3)	48.9	%	47.0	%	1.9	%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(2) The change is the difference between the amounts shown for the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

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

Total same-hospital admissions increased by 5,549, or 4.6%, in the three months ended September 30, 2014 compared to the three months ended September 30, 2013. Total surgeries increased by 14.4% in the three months ended September 30, 2014 compared to the same period in 2013, comprised of a 20.2% increase in outpatient surgeries primarily due to our outpatient development strategies and a 1.7% increase in inpatient surgeries. Our emergency department admissions increased 6.4% in the three months ended September 30, 2014 compared to the same period in the prior year. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a

result of the ACA, and a strengthening economy. Charity and uninsured admissions decreased 3.1% in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 primarily due to Medicaid expansion in California and health insurance exchange coverage under the ACA.

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	Same-Hospital Continuing Operations Three Months Ended September 30,					
Outpatient Visits	2014		2013		Increase (Decrease)	
Total visits	1,155,852		1,071,421		7.9	%
Paying visits (excludes charity and uninsured)	1,042,636		956,871		9.0	%
Charity and uninsured visits	113,216		114,550		(1.2)	%
Emergency department visits	433,174		400,345		8.2	%
Surgery visits	91,472		76,084		20.2	%
Paying visits as a percentage of total visits	90.2	%	89.3	%	0.9	%(1)
Charity and uninsured visits as a percentage of total visits	9.8	%	10.7	%	(0.9)	%(1)

(1) The change is the difference between the amounts shown for the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Total same-hospital outpatient visits increased 84,431, or 7.9%, in the three months ended September 30, 2014 compared to the three months ended September 30, 2013, which included 9.0% growth for paying visits. Approximately 81% of the growth in outpatient visits was organic.

Outpatient surgery visits increased by 20.2% in the three months ended September 30, 2014 compared to the same period in 2013. Charity and uninsured outpatient visits decreased by 1.2% in the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

	Same-Hospital Continuing Operations Three Months Ended September 30,			
Revenues	2014	2013	Increase (Decrease)	
Net operating revenues	$ 2,684	$ 2,408	11.5	%
Revenues from the uninsured	$ 150	$ 167	(10.2)	%
Net inpatient revenues(1)	$ 1,602	$ 1,502	6.7	%
Net outpatient revenues(1)	$ 924	$ 845	9.3	%

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient

revenues include self-pay revenues of $56 million and $68 million for the three months ended September 30, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $94 million and $99 million for the three months ended September 30, 2014 and 2013, respectively.

Net operating revenues increased by $276 million, or 11.5%, on a same-hospital basis in the three months ended September 30, 2014 compared to the same period in 2013, primarily due to increases in inpatient and outpatient volumes, improved managed care pricing, and increased revenues from services provided by our Conifer subsidiary to third parties. Revenues from the uninsured decreased 10.2% in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 primarily due to Medicaid expansion in California and health insurance exchange coverage under the ACA. Net operating revenues in the three months ended September 30, 2014 included $74 million of Medicaid disproportionate share hospital (“DSH”) and other state-funded subsidy revenues compared to $72 million in the same period in 2013 on a same-hospital basis. During the three months ended September 30, 2013, we recognized $19 million of net revenues related to the California provider fee program; we did not recognize any revenues related to this program during the three months ended September 30, 2014 because the current program has not been approved by CMS yet. Net patient revenues increased by 7.6% in the three months ended September 30, 2014 compared to the same period in 2013.

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	Same-Hospital Continuing Operations Three Months Ended September 30,		Increase
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	(Decrease)
Net inpatient revenue per admission	$ 12,602	$ 12,355	2.0 %
Net inpatient revenue per patient day	$ 2,694	$ 2,636	2.2 %
Net outpatient revenue per visit	$ 799	$ 789	1.3 %
Net patient revenue per adjusted patient admission(1)	$ 12,131	$ 11,928	1.7 %
Net patient revenue per adjusted patient day(1)	$ 2,626	$ 2,572	2.1 %

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Net inpatient revenue per admission and net outpatient revenue per visit increased 2.0% and 1.3%, respectively, in the three months ended September 30, 2014 compared to the same period in 2013. The increases were primarily due to improved terms of our managed care contracts.

	Same-Hospital Continuing Operations Three Months Ended September 30,		Increase
Provision for Doubtful Accounts	2014	2013	(Decrease)
Provision for doubtful accounts	$ 163	$ 210	(22.4)%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	5.7 %	8.0 %	(2.3) %(1)
Collection rate on self-pay accounts(2)	27.5 %	28.8 %	(1.3) %(1)
Collection rate on commercial managed care accounts	98.3 %	98.3 %	— %(1)

(1) The change is the difference between the amounts shown for the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

Provision for doubtful accounts decreased by $47 million, or 22.4%, in the three months ended September 30, 2014 compared to the same period in 2013. The decrease in the provision for doubtful accounts primarily related to the

decrease in revenues from the uninsured and the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the 130 basis point decrease in our self-pay collection rate, as well as higher patient co pays and deductibles. Our self-pay collection rate, which is the blended collection rate for uninsured and balance after insurance accounts receivable, was approximately 27.5% at September 30, 2014 and 28.8% at September 30, 2013.

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	Same-Hospital Continuing Operations Three Months Ended September 30,		
Selected Operating Expenses	2014	2013	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 1,150	$ 1,032	11.4 %
Supplies	416	387	7.5 %
Other operating expenses	587	526	11.6 %
Total	$ 2,153	$ 1,945	10.7 %
Conifer			
Salaries, wages and benefits	$ 182	$ 140	30.0 %
Other operating expenses	67	49	36.7 %
Total	$ 249	$ 189	31.7 %
Total			
Salaries, wages and benefits	$ 1,332	$ 1,172	13.7 %
Supplies	416	387	7.5 %
Other operating expenses	654	575	13.7 %
Total	$ 2,402	$ 2,134	12.6 %
Rent/lease expense(1)			
Hospital Operations and other	$ 37	$ 41	(9.8) %
Conifer	5	3	66.7 %
Total	$ 42	$ 44	(4.5) %
Hospital Operations and other(2)			
Salaries, wages and benefits per adjusted patient day	$ 1,193	$ 1,130	5.6 %
Supplies per adjusted patient day	432	424	1.9 %
Other operating expenses per adjusted patient day	593	565	5.0 %
Total per adjusted patient day	$ 2,218	$ 2,119	4.7 %
Salaries, wages and benefits per adjusted patient admission	$ 5,513	$ 5,240	5.2 %
Supplies per adjusted patient admission	1,998	1,967	1.6 %
Other operating expenses per adjusted patient admission	2,737	2,622	4.4 %
Total per adjusted patient admission	$ 10,248	$ 9,829	4.3 %

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

Total selected operating expenses, which is defined as salaries, wages and benefits, supplies and other operating expenses, increased by 4.7% and 4.3% on a per adjusted patient day and per adjusted patient admission basis,

respectively, in the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Salaries, wages and benefits per adjusted patient admission increased by approximately 5.2% in the three months ended September 30, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs in the three months ended September 30, 2014 compared to the three months ended September 30, 2013.

Supplies expense per adjusted patient admission increased by 1.6% in the three months ended September 30, 2014 compared to the three months ended September 30, 2013. The change in supplies expense was primarily attributable to higher costs for pharmaceuticals and volume growth in our supply-intensive surgical services.

Other operating expenses per adjusted patient admission increased by 4.4% in the three months ended September 30, 2014 compared to the same period in 2013. This change is due to increased costs of contracted services,

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higher medical fees primarily related to a greater number of employed and contracted physicians, increased malpractice expense and increased costs associated with funding indigent care services by certain of our Texas hospitals, which were substantially offset by additional net patient revenues. Malpractice expense in the 2014 period included a favorable adjustment of approximately $1 million due to a nine basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $2 million as a result of a six basis point increase in the interest rate in the 2013 period.

Salaries, wages and benefits expense for Conifer increased by $42 million in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Other operating expenses for Conifer increased by $18 million in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 primarily due to higher costs related to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

The table below shows the pre-tax and after-tax impact on continuing operations for the three and nine months ended September 30, 2014 and 2013 of the following items:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (37)	$ (20)	$ (90)	$ (45)
Litigation and investigation costs	(4)	(1)	(19)	(3)
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Pre-tax impact	$ (65)	$ (21)	$ (133)	$ (396)
Other tax adjustments	$ 14	$ —	$ 18	$ (6)
Total after-tax impact	$ (26)	$ (13)	$ (66)	$ (255)
Diluted per-share impact of above items	$ (0.26)	$ (0.13)	$ (0.68)	$ (2.45)
Diluted earnings per share, including above items	$ 0.10	$ 0.32	$ (0.27)	$ (1.03)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $200 million at September 30, 2014, a decrease of $206 million from $406 million at June 30, 2014.

Significant cash flow items in the three months ended September 30, 2014 included:

- $221 million of cash provided by operations;
- Capital expenditures of $211 million;
- Purchases of businesses for $143 million;
- Interest payments of $127 million;
- $493 million of net proceeds from the issuance of our 5 1/2% senior notes due 2019;
- $60 million of payments on our 9 7/8% senior notes due 2014; and
- $497 of net payments to redeem our 9 1/4% senior notes due 2015.

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Net cash provided by operating activities was $468 million in the nine months ended September 30, 2014 compared to $334 million in the nine months ended September 30, 2013. Key positive and negative factors contributing to the change between the 2014 and 2013 periods include the following:

- Increased income from continuing operations before income taxes of $408 million, excluding loss from early extinguishment of debt, interest expense, investment earnings, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization, in the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013;

- $11 million more cash used in operating activities from discontinued operations;

- An increase of $79 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and

- Higher interest payments of $192 million.

FORWARD-LOOKING STATEMENTS

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

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

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

SOURCES OF REVENUE

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

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The table below shows the sources of net patient revenues before provision for doubtful accounts for our continuing general hospitals, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Three Months Ended September 30,			Nine Months Ended September 30,		
Net Patient Revenues from:	2014	2013	Increase (Decrease)(1)	2014	2013	Increase (Decrease)(1)
Medicare	21.5 %	21.3 %	0.2 %	22.2 %	21.8 %	0.4 %
Medicaid	8.7 %	8.8 %	(0.1) %	8.8 %	8.9 %	(0.1) %
Managed care	60.7 %	58.8 %	1.9 %	58.8 %	58.2 %	0.6 %
Indemnity, self-pay and other	9.1 %	11.1 %	(2.0) %	10.2 %	11.1 %	(0.9) %

(1) The increase (decrease) is the difference between the 2014 and 2013 percentages shown.

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

	Three Months Ended September 30,			Nine Months Ended September 30,		
Admissions from:	2014	2013	Increase (Decrease)(1)	2014	2013	Increase (Decrease)(1)
Medicare	26.6 %	27.1 %	(0.5) %	27.6 %	28.2 %	(0.6) %
Medicaid	9.9 %	12.6 %	(2.7) %	10.8 %	12.1 %	(1.3) %
Managed care	56.1 %	49.6 %	6.5 %	53.9 %	49.3 %	4.6 %
Indemnity, self-pay and other	7.4 %	10.7 %	(3.3) %	7.7 %	10.4 %	(2.7) %

(1) The increase (decrease) is the difference between the 2014 and 2013 percentages shown.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services is the single largest payer of healthcare services in the United States. Nearly 90 million Americans rely on healthcare benefits through Medicare, Medicaid, and the Children's Health Insurance Program ("CHIP"). These three major programs are authorized by federal law and directed by CMS, an agency of the U.S. Department of Health and Human Services ("HHS"). Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with

end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP is also administered by the states and jointly funded and provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

The Affordable Care Act is changing how healthcare services in the United States are covered, delivered and reimbursed. One key provision of the ACA is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. For individuals who are not exempt from the individual mandate, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company or a health insurance exchange. Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. Earlier this year, two federal appeals court panels issued conflicting rulings on whether the government could subsidize health insurance premiums under the ACA. Pending further review of the issue by the courts, the government has stated that it will continue paying the subsidies to insurance companies on behalf of consumers in the 36 states that use the federal exchange. Also beginning in 2014, those who do not comply with the individual mandate must make a "shared responsibility payment" to the federal government in the form of a tax penalty. The "employer mandate" provision of the ACA requires the imposition of penalties on employers having 50 or more employees who do not offer affordable health insurance coverage to those working 30 or more hours per week. In July 2013, the U.S. Treasury Department announced a one-year delay (to January 1, 2015) in the imposition of penalties and the reporting requirements of the employer mandate. On February 10, 2014, the requirements of the employer mandate were further delayed until January 1, 2016. Based on the Congressional Budget Office's most recent estimates, we do not believe that the delays in the employer mandate will have a discernible effect on insurance coverage. Another

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key provision of the ACA is the expansion of Medicaid coverage. Prior to the passage of the ACA, the Medicaid program offered federal funding to states to assist only limited categories of low-income individuals (including children, pregnant women, the blind and the disabled) in obtaining medical care. The ACA expanded eligibility under existing Medicaid programs to virtually all individuals under 65 years old with incomes up to 138% of the federal poverty level beginning in 2014. Under the ACA, the federal government will pay 100% of the costs of Medicaid expansion in 2014, 2015 and 2016; federal funding will be reduced to 90% over the course of the four-year period from 2017 through 2020, and it will remain at 90% for 2021 and beyond. The expansion of the Medicaid program in each state will require state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. As of September 30, 2014, 27 states and the District of Columbia have taken action to expand Medicaid and two others are considering action to expand in the near future. We currently operate hospitals in five of the states that have expanded in 2014 and one of the states that is expanding in 2015. We cannot provide any assurances as to whether or when the other states in which we operate might choose to expand their Medicaid programs. We anticipate that healthcare providers will generally benefit over time from insurance coverage provisions of the ACA; however, the ACA also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including: (1) negative adjustments to the annual market basket updates for Medicare inpatient, outpatient, long-term acute and inpatient rehabilitation prospective payment systems, which began in 2010, as well as additional "productivity adjustments" that began in 2011; and (2) reductions to Medicare and Medicaid DSH payments, which began for Medicare payments in federal fiscal year ("FFY") 2014 and will begin for Medicaid payments in FFY 2017, as the number of uninsured individuals declines. We are unable to predict the net effect of the ACA on our future revenues and operations at this time due to uncertainty regarding the ultimate number of uninsured patients who will obtain insurance coverage, uncertainty regarding future negotiations with payers, uncertainty regarding Medicaid expansion, and gradual and, in some cases, delayed implementation. Furthermore, we are unable to predict the outcome of legal challenges to certain provisions (including the provisions regarding subsidies) of the ACA, what action, if any, Congress might take with respect to the ACA or the actions individual states might take with respect to expanding Medicaid coverage. For a discussion of the risks and uncertainties associated with the Affordable Care Act, including the future course of related legislation and regulations, see Item 1A, Risk Factors, of Part I of our Annual Report.

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

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred

provider organizations (“PPOs”), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues, including our general hospitals and other operations, for services provided to patients enrolled in the Original Medicare Plan for the three and nine months ended September 30, 2014 and 2013 are set forth in the following table:

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Revenue Descriptions	Three Months Ended September 30, 2014(1)	2013	Nine Months Ended September 30, 2014(1)	2013
Medicare severity-adjusted diagnosis-related group — operating	$ 407	$ 252	$ 1,248	$ 807
Medicare severity-adjusted diagnosis-related group — capital	37	22	114	70
Outliers	16	12	52	37
Outpatient	234	138	710	408
Disproportionate share	96	51	287	157
Direct Graduate and Indirect Medical Education(2)	55	24	186	76
Other(3)	30	6	55	19
Adjustments for prior-year cost reports and related valuation allowances	(1)	18	18	34
Total Medicare net patient revenues	$ 874	$ 523	$ 2,670	$ 1,608

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center, Resolute Health Hospital and Emanuel Medical Center.

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

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

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

Disproportionate Share Hospital Payments

As previously disclosed, the statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates ("FFY 2005 Final Rule"). During the three months ended December 31, 2012, the federal district court in the District of Columbia ruled in Allina Health Services v. Sebelius that the Secretary of HHS ("Secretary") failed to follow the Administrative Procedures Act when promulgating the regulation requiring the inclusion of the Medicare Advantage days in the DSH calculation. The court vacated the regulation and remanded the matter to the Secretary to recalculate the DSH reimbursement without using the interpretation set forth in the FFY 2005 Final Rule. The Secretary appealed the district court's decision to the U.S.

Court of Appeals for the D.C. Circuit ("Circuit Court"). On April 1, 2014, the Circuit Court: (1) affirmed the district court's order to vacate the regulation; (2) reversed the district court's order regarding the manner in which the reimbursement should be calculated; and (3) remanded the matter to HHS. During the three months ended June 30, 2014, the Secretary announced that HHS would not seek a rehearing at the Circuit Court or petition the U.S. Supreme Court to review the Circuit Court's decision. We are not able to predict what action the Secretary might take with respect to the DSH calculation; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Medicare Hospital Appeals Settlement

During the three months ended September 30, 2014, CMS offered hospitals an opportunity to settle certain Medicare inpatient claims in the appeals process or within the timeframe to request an appeal. Generally, the one-time settlement offer applies to payment denials for inpatient services on the basis that the services were reasonable and necessary, but treatment as an inpatient was not. All of our hospitals with claims that are eligible for settlement are accepting the settlement offer. The estimated cash value of the settlement for our hospitals' claims is approximately $18 million.

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Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 17.4% and 15.7% of net patient revenues before provision for doubtful accounts at our continuing general hospitals for the nine months ended September 30, 2014 and 2013, respectively. We also receive DSH payments under various state Medicaid programs. For the nine months ended September 30, 2014 and 2013, our revenues attributable to DSH payments and other state-funded subsidy payments for our continuing operations were approximately $493 million and $257 million, respectively.

Several states in which we operate continue to face budgetary challenges due to the slow economic recovery and other factors that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state’s budget, states can be expected to adopt or consider adopting future legislation designed to reduce their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

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

Medicaid-related patient revenues recognized by our continuing general hospitals from Medicaid-related programs in the states in which they are located, as well as from Medicaid programs in neighboring states, for the nine months ended September 30, 2014 and 2013 are set forth in the table below:

	Nine Months Ended September 30,			
	2014(1)		2013	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Michigan	$ 253	$ 197	$ —	$ —
Texas	208	174	84	93
Florida	134	68	136	47

California	108	180	188	123
Illinois	62	23	—	—
Georgia	57	27	60	25
Pennsylvania	57	145	55	148
Missouri	51	6	49	5
Massachusetts	28	35	—	—
North Carolina	22	6	25	3
South Carolina	12	23	18	19
Alabama	10	—	10	—
Arizona	5	87	—	—
Tennessee	5	22	5	21
	$ 1,012	$ 993	$ 630	$ 484

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center, Resolute Health Hospital and Emanuel Medical Center.

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Regulatory and Legislative Changes

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

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year. On August 4, 2014, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2015 Rates, and, on October 3, 2014, CMS issued a Correction Notice to the August 4, 2014 rule (together, the "Final IPPS Rule"). The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.9% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of EHR technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology would receive a reduced market basket increase); CMS is also making certain adjustments to the estimated 2.9% market basket increase that result in a net market basket update of 1.4% (before budget neutrality adjustments), including:

- Market basket index and multifactor productivity reductions required by the ACA of 0.2% and 0.5%, respectively; and

- A documentation and coding recoupment reduction of 0.8% as required by the American Taxpayer Relief Act of 2012;

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

- Implementation of a 1% payment decrease for hospitals that rank in the top 25% of CMS' measurement of hospital acquired conditions;

- Updates to the Core Based Statistical Areas that affect the wage index used to adjust MS-DRG payments for geographic differences;

· A 1.32% net increase in the capital federal MS-DRG rate; and

· An increase in the cost outlier threshold from $21,748 to $24,626.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 0.6% decrease in payments for hospitals in large urban areas (populations over one million). Using the impact percentages in the Final IPPS Rule as applied to our IPPS payments for the 12 months ended September 30, 2014, the estimated annual impact for all changes in the Final IPPS Rule on our hospitals is a decrease in our Medicare inpatient revenues of approximately $13 million, most of which is related to an expected decrease in UC-DSH reimbursement. Because of the uncertainty regarding factors that may influence our future IPPS payments by individual hospital, including admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate.

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Payment and Policy Changes to the Medicare Inpatient Psychiatric Facility Prospective Payment System

On July 31, 2014, CMS issued a final rule updating Medicare payment policies and rates for the Medicare inpatient psychiatric facility ("IPF") prospective payment system for FFY 2015 ("IPF-PPS Final Rule"). The IPF-PPS Final Rule includes the following payment and policy change for IPFs:

- A net payment increase for IPFs of 2.1%, which reflects a market basket increase of 2.9% reduced by market basket index and multifactor productivity adjustments required by the ACA of 0.3% and 0.5%, respectively; and

- A decrease in the outlier fixed-dollar loss threshold from $10,245 to $8,755.

At September 30, 2014, 21 of our general hospitals operated IPF units. CMS projects that the payment changes in the IPF-PPS Final Rule will result in an estimated total increase in aggregate IPF payments of 2.5%, which includes an average 2.7% increase for IPF units in hospitals located in urban areas for FFY 2015. Using the urban IPF unit impact percentage as applied to our Medicare IPF payments for the 12 months ended September 30, 2014, the annual impact of the payment and policy changes in the IPF-PPS Final Rule may result in an estimated increase in our Medicare revenues of approximately $1 million. Because of the uncertainty associated with various factors that may influence our future IPF payments, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of these changes.

Payment and Policy Changes to the Medicare Inpatient Rehabilitation Facility Prospective Payment System

On July 31, 2014, CMS issued a final rule updating Medicare payment policies and rates for the Medicare inpatient rehabilitation facility ("IRF") prospective payment system for FFY 2015 ("IRF-PPS Final Rule"). The IRF-PPS Final Rule includes the following payment and policy changes for IRFs:

- A net payment increase for IRFs of 2.2%, which reflects a market basket increase of 2.9% reduced by market basket index and multifactor productivity adjustments required by the ACA of 0.2% and 0.5%, respectively; and

- An additional 0.2% aggregate payment increase due to updated outlier threshold results.

At September 30, 2014, we operated one freestanding IRF, and 14 of our general hospitals operated IRF units. CMS projects that the payment changes in the IRF-PPS Final Rule will result in an estimated total increase in aggregate IRF payments of 2.4%, which includes an average 2.2% increase for freestanding IRFs, and an average 2.6% increase for IRF units in hospitals located in urban areas for FFY 2015. Using the applicable freestanding and urban IRF unit

impact percentages as applied to our Medicare IRF payments for the 12 months ended September 30, 2014, the annual impact of the payment and policy changes in the IRF-PPS Final Rule may result in an estimated increase in our Medicare revenues of approximately $1 million. Because of the uncertainty associated with various factors that may influence our future IRF payments, including legislative action, admission volumes, length of stay and case mix, as well as the related effects of compliance with admission criteria, we cannot provide any assurances regarding our estimate of the impact of these changes.

Payment and Policy Changes to the Medicare Outpatient Prospective Payment System

On October 31, 2014, CMS released the Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems changes for calendar year 2015 (“OPPS Final Rule”). The OPPS Final Rule includes the following payment and policy changes:

- An estimated market basket increase of 2.9%, minus market basket index and multifactor productivity reductions required by the ACA of 0.2% and 0.5%, respectively; and
- An expansion of the items and services that are packaged into the outpatient prospective payment system (“OPPS”) payments.

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CMS projects that the combined impact of the payment and policy changes in the OPPS Final Rule will yield an average 2.3% increase in OPPS payments for all hospitals and an average 2.5% increase in OPPS payments for hospitals in large urban areas (populations over one million). According to CMS' estimates, the projected annual impact of the payment and policy changes in the OPPS Final Rule on our hospitals is a $13 million increase in Medicare outpatient revenues. Because of the uncertainty associated with other factors that may influence our future OPPS payments by individual hospital, including legislative action, patient volumes and case mix, we cannot provide any assurances regarding this estimate.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On October 31, 2014, CMS released the update to the Medicare Physician Fee Schedule ("MPFS"). The MPFS is the schedule of rates Medicare pays for physician and other professional services and is updated annually. The MPFS update is determined by the "sustainable growth rate" ("SGR") formula in accordance with the Balanced Budget Act of 1997. The Protecting Access to Medicare Act of 2014 ("PAMA"), described below, includes a zero percent update to the 2015 MPFS through March 31, 2015. However, the SGR takes effect on April 1, 2015 unless Congress intervenes. In March 2014 (prior to the enactment of the PAMA), CMS estimated that the MPFS SGR-based update for calendar year 2015 would be a reduction of 20.9%. In most prior years, Congress has taken action to avert a large reduction in MPFS rates before it went into effect. These actions have often resulted in payment reductions to other health care providers (including hospitals) to maintain budget neutrality. Although the historical pattern suggests that Congress will override the SGR formula for the nine months commencing April 1, 2015, we cannot provide any assurances in that regard. In addition, we cannot predict the level or type of payment reductions affecting our hospitals that might be used to offset a temporary override or permanent replacement of the SGR formula.

The Protecting Access to Medicare Act of 2014

On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014. This new law prevented a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on April 1, 2014. The law includes the following provisions:

- An extension of the 0.5% update for services reimbursed under the MPFS that applied from January 1, 2014 through March 31, 2014 for the period April 1, 2014 through December 31, 2014;

- A zero percent update to the 2015 MPFS through March 31, 2015;

- A delay in the implementation of ICD-10 (as discussed in our Annual Report) from October 1, 2014 until at least October 1, 2015 (based on recent CMS announcements, we expect the use of ICD-10 to begin on October 1, 2015);

- An additional one-year delay of the ACA Medicaid DSH reduction to October 1, 2016 (funding of this delay will be achieved by a net increase in the FFY 2017 through 2023 ACA Medicaid DSH reductions);

- A one-year extension of the ACA Medicaid DSH reduction through FFY 2024;

- A six-month partial extension of the moratorium on enforcement of the “two-midnight rule” (as discussed in our Annual Report) through March 31, 2015; and

- Modification of the FFY 2024 Medicare sequestration consisting of a 4% increase to the sequestration reduction for the first six months of FFY 2024, and then a decrease of the reduction to zero percent for the second six months of that FFY.

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PRIVATE INSURANCE

Managed Care

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

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

The amount of our managed care net patient revenues during the nine months ended September 30, 2014 and 2013 was $6.8 billion and $4.1 billion, respectively. Approximately 62% of our managed care net patient revenues for the nine months ended September 30, 2014 was derived from our top ten managed care payers. National payers generated approximately 46% of our total net managed care revenues. The remainder comes from regional or local payers. At September 30, 2014 and December 31, 2013, approximately 61% and 58%, respectively, of our net accounts receivable related to continuing operations were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient’s bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves as of September 30, 2014, a 3% increase or decrease in the estimated contractual allowances would impact the estimated reserves by approximately $13 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders

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

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have experienced improved year-over-year managed care pricing, we expect some moderation in the pricing percentage increases in future years. In the nine months ended September 30, 2014, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 74% higher than our aggregate yield on a per admission basis from governmental payers, including managed Medicare and Medicaid insurance plans.

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Indemnity

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

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant portion of our self-pay patients is admitted through our hospitals' emergency departments and often requires high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts. We believe that our level of self-pay patients has been higher in the last several years than previous periods due to a combination of broad economic factors, including high unemployment rates in some of the markets our hospitals serve, reductions in state Medicaid budgets, increasing numbers of individuals and employers who choose not to purchase insurance, and an increased burden of co-pays and deductibles to be made by patients instead of insurers.

Self-pay accounts pose significant collectability problems. At September 30, 2014 and December 31, 2013, approximately 6% and 7%, respectively, of our net accounts receivable related to continuing operations were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have been increasing our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

Over the longer term, several other initiatives we have previously announced should also help address this challenge. For example, our Compact with Uninsured Patients ("Compact") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically have been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual

allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

Under the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), a new Consumer Financial Protection Bureau ("CFPB") was formed within the U.S. Federal Reserve to promote transparency, simplicity, fairness, accountability and equal access in the market for consumer financial products or services, including debt collection services. The Dodd-Frank Act gives significant discretion to the CFPB in establishing regulatory requirements and enforcement priorities. We believe that the CFPB regulatory and enforcement processes will have a significant impact on the operations of Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC. For additional information, see Item 1, Business – Regulations Affecting Conifer, of Part I of our Annual Report and Item 1, Legal Proceedings, in Part II of this report.

Our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients for the three months ended September 30, 2014 and 2013 were approximately $135 million and $116 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $488 million and $342 million, respectively. (All 2014 amounts in

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this paragraph include the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as Texas Regional Medical Center, Resolute Health Hospital and Emanuel Medical Center.) We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. Revenues attributable to DSH payments and other state-funded subsidy payments for the three months ended September 30, 2014 and 2013 were approximately $178 million and $72 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $493 million and $257 million, respectively. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Our estimated costs (based on the selected operating expenses described above) of caring for charity care patients for the three months ended September 30, 2014 and 2013 were approximately $42 million and $32 million, respectively, and for the nine months ended September 30, 2014 and 2013 were approximately $137 million and $95 million, respectively. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues.

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, even with the implementation of the ACA, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage under the ACA and for persons living in the country without legal permission who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

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RESULTS OF OPERATIONS

The following two tables summarize our net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the three and nine months ended September 30, 2014 and 2013:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues:				
General hospitals	$ 3,912	$ 2,361	$ 11,576	$ 7,135
Other operations	516	257	1,520	706
Net operating revenues before provision for doubtful accounts	4,428	2,618	13,096	7,841
Less provision for doubtful accounts	249	210	949	624
Net operating revenues	4,179	2,408	12,147	7,217
Operating expenses:				
Salaries, wages and benefits	2,028	1,172	5,905	3,499
Supplies	665	387	1,942	1,158
Other operating expenses, net	1,032	575	3,066	1,710
Electronic health record incentives	(5)	(14)	(72)	(48)
Depreciation and amortization	207	119	609	354
Impairment and restructuring charges, and acquisition-related costs	37	20	90	45
Litigation and investigation costs	4	1	19	3
Operating income	$ 211	$ 148	$ 588	$ 496

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net operating revenues	100.0 %	100.0 %	100.0 %	100.0 %
Operating expenses:				
Salaries, wages and benefits	48.5 %	48.7 %	48.6 %	48.5 %
Supplies	15.9 %	16.1 %	16.0 %	16.0 %
Other operating expenses, net	24.7 %	24.0 %	25.3 %	23.8 %
Electronic health record incentives	(0.1) %	(0.6) %	(0.6) %	(0.7) %
Depreciation and amortization	5.0 %	4.9 %	5.0 %	4.9 %
Impairment and restructuring charges, and acquisition-related costs	0.9 %	0.8 %	0.7 %	0.6 %
Litigation and investigation costs	0.1 %	— %	0.2 %	— %

Operating income	5.0	%	6.1	%	4.8	%	6.9	%

Net operating revenues of our general hospitals include inpatient and outpatient revenues, as well as nonpatient revenues (rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) services provided by our Conifer subsidiary to third parties and (4) our health plans acquired from Vanguard. Revenues from our general hospitals represented approximately 88% and 90% of our total net operating revenues before provision for doubtful accounts for the three months ended September 30, 2014 and 2013, respectively, and approximately 88% and 91% for the nine months ended September 30, 2014 and 2013, respectively.

Net operating revenues from our other operations were $516 million and $257 million in the three months ended September 30, 2014 and 2013, respectively, and $1.520 billion and $706 million in the nine months ended September 30, 2014 and 2013, respectively. The increase in net operating revenues from other operations during 2014 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our health plans acquired from Vanguard and additional physician practices. Equity earnings of unconsolidated affiliates included in our

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net operating revenues from other operations were $4 million and $1 million for the three months ended September 30, 2014 and 2013, respectively, and $9 million and $13 million in the nine months ended September 30, 2014 and 2013, respectively. Included in 2013 equity earnings of unconsolidated affiliates is $10 million of earnings associated with stepping up our basis in a previously held investment in an ambulatory surgery center in which we acquired a controlling interest and are now consolidating.

The following table shows certain selected operating statistics for our continuing operations on a total hospital basis, which includes the results of the 28 hospitals we acquired from Vanguard on October 1, 2013, Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014, in each case only for the period of time from such acquisition or opening to September 30, 2014. We believe this information is useful to investors because it reflects our current portfolio of hospitals and the significant increase in the scale of our operations as a result of these investments.

	Total Hospital Continuing Operations Three Months Ended September 30,			Nine Months Ended September 30,		
	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total admissions	199,914	121,569	64.4 %	588,828	368,220	59.9 %
Adjusted patient admissions(1)	345,787	196,761	75.7 %	1,007,106	589,866	70.7 %
Paying admissions (excludes charity and uninsured)	188,924	112,760	67.5 %	554,381	341,977	62.1 %
Charity and uninsured admissions	10,990	8,809	24.8 %	34,447	26,243	31.3 %
Admissions through emergency department	123,147	75,512	63.1 %	367,834	231,328	59.0 %
Emergency department visits	719,835	400,345	79.8 %	2,086,846	1,202,125	73.6 %
Total emergency department	842,982	475,857	77.2 %	2,454,680	1,433,453	71.2 %

admissions and visits												
Surgeries — inpatient	55,339		34,971		58.2	%	160,186		102,515		56.3	%
Surgeries — outpatient	123,100		76,084		61.8	%	354,199		218,622		62.0	%
Total surgeries	178,439		111,055		60.7	%	514,385		321,137		60.2	%
Patient days — total	921,228		569,833		61.7	%	2,757,485		1,740,508		58.4	%
Adjusted patient days(1)	1,574,346		912,483		72.5	%	4,663,406		2,762,043		68.8	%
Average length of stay (days)	4.61		4.69		(1.7)	%	4.68		4.73		(1.1)	%
Average licensed beds	20,692		13,180		57.0	%	20,439		13,180		55.1	%
Utilization of licensed beds(2)	48.4	%	47.0	%	1.4	%(3)	49.4	%	48.4	%	1.0	%(3)
Total visits	2,125,002		1,071,421		98.3	%	6,138,740		3,198,922		91.9	%
Paying visits (excludes charity and uninsured)	1,954,980		956,871		104.3	%	5,633,704		2,859,799		97.0	%
Charity and uninsured visits	170,022		114,550		48.4	%	505,036		339,123		48.9	%
Net inpatient revenues	$ 2,463		$ 1,502		64.0	%	$ 7,296		$ 4,580		59.3	%
Net outpatient revenues	$ 1,441		$ 845		70.5	%	$ 4,235		$ 2,502		69.3	%
Net inpatient revenue per admission	$ 12,320		$ 12,355		(0.3)	%	$ 12,391		$ 12,438		(0.4)	%
Net inpatient revenue per patient day	$ 2,674		$ 2,636		1.4	%	$ 2,646		$ 2,631		0.6	%
Net outpatient revenue per visit	$ 678		$ 789		(14.1)	%	$ 690		$ 782		(11.8)	%
Net patient revenue per adjusted patient admission(1)	$ 11,290		$ 11,928		(5.3)	%	$ 11,450		$ 12,006		(4.6)	%
Net patient revenue per adjusted patient day(1)	$ 2,480		$ 2,572		(3.6)	%	$ 2,473		$ 2,564		(3.5)	%

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(2)

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

(3) The change is the difference between the 2014 and 2013 amounts shown.

The tables below show certain selected historical operating statistics of our continuing hospitals on a same-hospital basis, where noted, excluding the results of the 28 hospitals we acquired from Vanguard on October 1, 2013,

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Texas Regional Medical Center, in which we acquired a majority interest on June 3, 2014, Resolute Health Hospital, which we opened on June 24, 2014, and Emanuel Medical Center, which we acquired on August 1, 2014.

	Same-Hospital Continuing Operations											
	Three Months Ended September 30,						Nine Months Ended September 30,					
Admissions, Patient Days and Surgeries	2014		2013		Increase (Decrease)		2014		2013		Increase (Decrease)	
Total admissions	127,118		121,569		4.6	%	376,289		368,220		2.2	%
Adjusted patient admissions(1)	208,229		196,761		5.8	%	609,721		589,866		3.4	%
Paying admissions (excludes charity and uninsured)	118,580		112,760		5.2	%	351,445		341,977		2.8	%
Charity and uninsured admissions	8,538		8,809		(3.1)	%	24,844		26,243		(5.3)	%
Admissions through emergency department	80,328		75,512		6.4	%	241,767		231,328		4.5	%
Paying admissions as a percentage of total admissions	93.3	%	92.8	%	0.5	%(2)	93.4	%	92.9	%	0.5	%(2)
Charity and uninsured admissions as a percentage of total admissions	6.7	%	7.2	%	(0.5)	%(2)	6.6	%	7.1	%	(0.5)	%(2)
Emergency department admissions as a percentage of total admissions	63.2	%	62.1	%	1.1	%(2)	64.3	%	62.8	%	1.5	%(2)
Surgeries — inpatient	35,570		34,971		1.7	%	103,468		102,515		0.9	%
Surgeries — outpatient	91,472		76,084		20.2	%	262,460		218,622		20.1	%
Total surgeries	127,042		111,055		14.4	%	365,928		321,137		13.9	%
Patient days — total	594,664		569,833		4.4	%	1,783,957		1,740,508		2.5	%
Adjusted patient days(1)	962,054		912,483		5.4	%	2,859,601		2,762,043		3.5	%
Average length of stay (days)	4.68		4.69		(0.2)	%	4.74		4.73		0.2	%
Number of acute care hospitals (at end of period)	49		49		—		49		49		—	
Licensed beds (at end of period)	13,231		13,180		0.4	%	13,231		13,180		0.4	%
Average licensed beds	13,231		13,180		0.4	%	13,202		13,180		0.2	%
Utilization of licensed beds(3)	48.9	%	47.0	%	1.9	%(2)	49.5	%	48.4	%	1.1	%(2)

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(2) The change is the difference between 2014 and 2013 amounts shown.

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

	Same-Hospital Continuing Operations Three Months Ended September 30,			Nine Months Ended September 30,		
Outpatient Visits	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Total visits	1,155,852	1,071,421	7.9 %	3,377,121	3,198,922	5.6 %
Paying visits (excludes charity and uninsured)	1,042,636	956,871	9.0 %	3,043,373	2,859,799	6.4 %
Charity and uninsured visits	113,216	114,550	(1.2) %	333,748	339,123	(1.6) %
Emergency department visits	433,174	400,345	8.2 %	1,280,225	1,202,125	6.5 %
Surgery visits	91,472	76,084	20.2 %	262,460	218,622	20.1 %
Paying visits as a percentage of total visits	90.2 %	89.3 %	0.9 %(1)	90.1 %	89.4 %	0.7 %(1)
Charity and uninsured visits as a percentage of total visits	9.8 %	10.7 %	(0.9) %(1)	9.9 %	10.6 %	(0.7) %(1)

(1) The change is the difference between 2014 and 2013 amounts shown.

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	Same-Hospital Continuing Operations Three Months Ended September 30,			Nine Months Ended September 30,		
Revenues	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Net operating revenues	$ 2,684	$ 2,408	11.5 %	$ 7,775	$ 7,217	7.7 %
Revenues from the uninsured	$ 150	$ 167	(10.2) %	$ 467	$ 502	(7.0) %
Net inpatient revenues(1)	$ 1,602	$ 1,502	6.7 %	$ 4,711	$ 4,580	2.9 %
Net outpatient revenues(1)	$ 924	$ 845	9.3 %	$ 2,710	$ 2,502	8.3 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $56 million and $68 million for the three months ended September 30, 2014 and 2013, respectively, and $181 million and $207 million for the nine months ended September 30, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $94 million and $99 million for the three months ended September 30, 2014 and 2013, respectively, and $286 million and $295 million for the nine months ended September 30, 2014 and 2013, respectively.

	Same-Hospital Continuing Operations Three Months Ended September 30,			Nine Months Ended September 30,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 12,602	$ 12,355	2.0 %	$ 12,520	$ 12,438	0.7 %
Net inpatient revenue per patient day	$ 2,694	$ 2,636	2.2 %	$ 2,641	$ 2,631	0.4 %
Net outpatient revenue per visit	$ 799	$ 789	1.3 %	$ 802	$ 782	2.6 %
Net patient revenue per adjusted patient admission(1)	$ 12,131	$ 11,928	1.7 %	$ 12,171	$ 12,006	1.4 %
Net patient revenue per adjusted patient day(1)	$ 2,626	$ 2,572	2.1 %	$ 2,595	$ 2,564	1.2 %

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

	Same-Hospital Continuing Operations Three Months Ended September 30,			Nine Months Ended September 30,		
Provision for Doubtful Accounts	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)

Provision for doubtful accounts	$ 163	$ 210	(22.4)%	$ 602	$ 624	(3.5)%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	5.7 %	8.0 %	(2.3) %(1)	7.2 %	8.0 %	(0.8)%(1)
Collection rate on self-pay accounts(2)	27.5 %	28.8 %	(1.3) %(1)	27.5 %	28.8 %	(1.3)%(1)
Collection rate on commercial managed care accounts	98.3 %	98.3 %	— %(1)	98.3 %	98.3 %	— %(1)

(1) The change is the difference between the 2014 and 2013 amounts shown.

(2) Self-pay accounts receivable are comprised of both uninsured and balance after insurance receivables.

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	Same-Hospital Continuing Operations Three Months Ended September 30,			Nine Months Ended September 30,		
Selected Operating Expenses	2014	2013	Increase (Decrease)	2014	2013	Increase (Decrease)
Hospital Operations and other						
Salaries, wages and benefits	$ 1,150	$ 1,032	11.4 %	$ 3,330	$ 3,092	7.7 %
Supplies	416	387	7.5 %	1,232	1,158	6.4 %
Other operating expenses	587	526	11.6 %	1,740	1,558	11.7 %
Total	$ 2,153	$ 1,945	10.7 %	$ 6,302	$ 5,808	8.5 %
Conifer						
Salaries, wages and benefits	$ 182	$ 140	30.0 %	$ 531	$ 407	30.5 %
Other operating expenses	67	49	36.7 %	196	152	28.9 %
Total	$ 249	$ 189	31.7 %	$ 727	$ 559	30.1 %
Total						
Salaries, wages and benefits	$ 1,332	$ 1,172	13.7 %	$ 3,861	$ 3,499	10.3 %
Supplies	416	387	7.5 %	1,232	1,158	6.4 %
Other operating expenses	654	575	13.7 %	1,936	1,710	13.2 %
Total	$ 2,402	$ 2,134	12.6 %	$ 7,029	$ 6,367	10.4 %
Rent/lease expense(1)						
Hospital Operations and other	$ 37	$ 41	(9.8) %	$ 105	$ 118	(11.0) %
Conifer	5	3	66.7 %	16	10	60.0 %
Total	$ 42	$ 44	(4.5) %	$ 121	$ 128	(5.5) %
Hospital Operations and other(2)						
Salaries, wages and benefits per adjusted patient day	$ 1,193	$ 1,130	5.6 %	$ 1,162	$ 1,119	3.8 %
Supplies per adjusted patient day	432	424	1.9 %	431	419	2.9 %
Other operating expenses per adjusted patient day	593	565	5.0 %	591	561	5.3 %
Total per adjusted patient day	$ 2,218	$ 2,119	4.7 %	$ 2,184	$ 2,099	4.0 %
Salaries, wages and benefits per adjusted patient admission	$ 5,513	$ 5,240	5.2 %	$ 5,452	$ 5,240	4.0 %
Supplies per adjusted patient admission	1,998	1,967	1.6 %	2,021	1,963	3.0 %
Other operating expenses per adjusted patient admission	2,737	2,622	4.4 %	2,769	2,625	5.5 %
Total per adjusted patient admission	$ 10,248	$ 9,829	4.3 %	$ 10,242	$ 9,828	4.2 %

(1) Included in other operating expenses.

(2) Adjusted patient days/admissions represents actual patient days/admissions adjusted to include outpatient services by multiplying actual patient days/admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues. These metrics exclude the expenses related to the provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals, which we acquired during the three months ended September 30, 2013.

THREE MONTHS ENDED SEPTEMBER 30, 2014 COMPARED TO THREE MONTHS ENDED SEPTEMBER 30, 2013

Revenues

During the three months ended September 30, 2014, same-hospital net operating revenues increased 11.5% compared to the three months ended September 30, 2013, primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts, and increased revenues from services provided by our Conifer subsidiary to third parties.

Our same-hospital net outpatient revenues and total outpatient visits increased 9.3% and 7.9%, respectively, during the three months ended September 30, 2014 compared to the same period in 2013. Outpatient revenues and volume growth was primarily driven by improved terms of our managed care contracts, increased outpatient volume levels and our outpatient development program. Net outpatient revenue per visit increased 1.3% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $296 million and $225 million for the three months ended September 30, 2014 and 2013, respectively, a portion of which was eliminated in consolidation as described in Note 15 to the Condensed Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients and expanded service offerings.

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Same-hospital patient days increased by 4.4% during the three months ended September 30, 2014 compared to the three months ended September 30, 2013. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy. We believe our inpatient volume levels continue to be constrained by an increase in patients with high-deductible health insurance plans and industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than an inpatient setting.

Provision for Doubtful Accounts

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 5.7% for the three months ended September 30, 2014 compared to 8.0% for the three months ended September 30, 2013. The decrease in the provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts primarily related to the decrease in uninsured patient revenues and the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the 130 basis point decrease in our self-pay collection rate, as well as higher patient co-pays and deductibles. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at September 30, 2014 and December 31, 2013:

	September 30, 2014			December 31, 2013		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 358	$ —	$ 358	$ 301	$ —	$ 301
Medicaid	153	—	153	133	—	133
Net cost report settlements payable and valuation allowances	(91)	—	(91)	(75)	—	(75)
Managed care	1,458	90	1,368	1,179	69	1,110
Self-pay uninsured	476	416	60	344	290	54
Self-pay balance after insurance	208	128	80	224	141	83
Estimated future recoveries from accounts assigned to our Conifer subsidiary	122	—	122	92	—	92
Other payers	324	138	186	278	89	189
Total continuing operations	3,008	772	2,236	2,476	589	1,887
Total discontinued operations	3	1	2	3	—	3
	$ 3,011	$ 773	$ 2,238	$ 2,479	$ 589	$ 1,890

We provide revenue cycle management and patient communications services, among others, through our Conifer subsidiary, which has performed systematic analyses to focus our attention on the drivers of bad debt for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have increased our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We are dedicated to modifying and refining our processes as needed, enhancing our technology, and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years, as we have experienced adverse changes in our business mix. At September 30, 2014, our same-hospital collection rate on self-pay accounts was approximately 27.5%. Our recent same-hospital self-pay collection rates were as follows: 28.8% at March 31, 2013; 28.7% at June 30, 2013; 28.8% at September 30, 2013; 28.7% at December 31, 2013; 28.1% at March 31, 2014; and 27.8% at June 30, 2014. These self-pay collection rates include payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at September 30, 2014, a 10% decrease or increase in our self-pay collection rate, or approximately 3%,

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which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $10 million.

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated same-hospital collection rate from managed care payers was approximately 98.3% at both September 30, 2014 and December 31, 2013.

Conifer continues to focus on revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collection at point-of-service, and financial counseling. The goals of the effort are focused on reducing denials, improving service levels to patients and increasing the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) accounts receivable days outstanding (“AR Days”), and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from continuing operations of $2.327 billion and $1.962 billion at September 30, 2014 and December 31, 2013, respectively, excluding cost report settlements payable and valuation allowances of $91 million and $75 million at September 30, 2014 and December 31, 2013, respectively:

	September 30, 2014									
	Medicare		Medicaid		Managed Care		Indemnity, Self-Pay and Other		Total	
0-60 days	83	%	49	%	68	%	28	%	62	%
61-120 days	7	%	20	%	14	%	18	%	14	%
121-180 days	4	%	11	%	6	%	11	%	7	%
Over 180 days	6	%	20	%	12	%	43	%	17	%
Total	100	%	100	%	100	%	100	%	100	%

December 31, 2013

	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	76 %	58 %	73 %	32 %	65 %
61-120 days	9 %	21 %	13 %	17 %	14 %
121-180 days	4 %	9 %	5 %	7 %	6 %
Over 180 days	11 %	12 %	9 %	44 %	15 %
Total	100 %	100 %	100 %	100 %	100 %

Our AR Days from continuing operations were 49.3 days at September 30, 2014 and 44.7 days at December 31, 2013, within our target of less than 55 days. AR Days are calculated as our accounts receivable from continuing operations on the last date in the quarter divided by our net operating revenues from continuing operations for the quarter ended on that date divided by the number of days in the quarter.

As of September 30, 2014, we had a cumulative total of patient account assignments to our Conifer subsidiary dating back at least three years or older of approximately $2.9 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer’s Medicaid Eligibility Program (“MEP”) screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the

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process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. At the present time, our newly acquired facilities are beginning to implement this program. Based on recent trends, approximately 92% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at September 30, 2014 and December 31, 2013 by aging category on a same-hospital basis:

	September 30, 2014	December 31, 2013
0-60 days	$ 85	$ 132
61-120 days	19	28
121-180 days	7	8
Over 180 days	17	18
Total	$ 128	$ 186

Salaries, Wages and Benefits

Salaries, wages and benefits expense as a percentage of net operating revenues decreased 0.2% for the three months ended September 30, 2014 compared to the three months ended September 30, 2013. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 5.2% in the three months ended September 30, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs. Salaries, wages and benefits expense for the three months ended September 30, 2014 and 2013 included stock-based compensation expense of $13 million and $7 million, respectively.

Salaries, wages and benefits expense for Conifer increased by $42 million in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 due to an increase in employee headcount as a result of the growth in Conifer’s business primarily attributable to the integration of the Vanguard facilities’ revenue cycle operations now managed by Conifer.

As of September 30, 2014, approximately 20% of our employees were represented by labor unions. These employees — primarily registered nurses and service and maintenance workers — are located at 39 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have five expired contracts and are negotiating renewals under extension agreements. We are also negotiating first contracts at two of our hospitals where employees selected

union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation.

Supplies

Supplies expense as a percentage of net operating revenues decreased 0.2% for the three months ended September 30, 2014 compared to the three months ended September 30, 2013. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 1.6% in the three months ended September 30, 2014 compared to the same period in 2013. The change in supplies expense per adjusted patient admission was primarily attributable to higher costs for pharmaceuticals and volume growth in our supply-intensive surgical services.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, bulk purchases and operational improvements. The items of current cost reduction focus continue to be cardiac stents and pacemakers, orthopedics and implants, and high-cost pharmaceuticals. We also utilize group-purchasing strategies and supplies-management services in an effort to reduce costs.

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Other Operating Expenses, Net

Other operating expenses as a percentage of net operating revenues was 24.7% in the three months ended September 30, 2014 compared to 24.0% in the three months ended September 30, 2013. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 4.4% in the three months ended September 30, 2014 compared to the same period in 2013. The 11.6% increase in same-hospital other operating expenses in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 is due to:

- increased costs of contracted services ($13 million);

- increased costs associated with funding indigent care services by certain of our Texas hospitals ($13 million) which were substantially offset by additional net patient revenues;

- higher medical fees primarily related to a greater number of employed and contracted physicians ($8 million); and

- increased malpractice expense ($11 million).

Malpractice expense in the three months ended September 30, 2014 included a favorable adjustment of approximately $1 million due to a nine basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to favorable adjustment of approximately $2 million as a result of a six basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $18 million in the three months ended September 30, 2014 compared to the three months ended September 30, 2013 primarily due to higher costs related to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the three months ended September 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $37 million, consisting of $5 million of employee severance costs, $6 million of contract and lease termination fees, $1 million of restructuring costs, and $25 million in acquisition-related costs, which include $3 million of transaction costs and $22 million of acquisition integration charges.

During the three months ended September 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $20 million, consisting of $4 million of employee severance costs, $3 million of restructuring costs and $13 million in acquisition-related costs.

Litigation and Investigation Costs

Litigation and investigation costs for the three months ended September 30, 2014 and 2013 were $4 million and $1 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

Interest Expense

Interest expense for the three months ended September 30, 2014 was $186 million compared to $91 million for the three months ended September 30, 2013, primarily due to increased borrowings relating to our recent acquisitions.

Loss from Early Extinguishment of Debt

During the three months ended September 30, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9$^{1}/_{4}$% senior notes due 2015 that we redeemed in the period, as well as the write-off of associated unamortized note discounts and issuance costs.

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Income Tax (Benefit) Expense

During the three months ended September 30, 2014, we recorded income tax benefit of $18 million compared to income tax expense of $16 million during the three months ended September 30, 2013. The benefit recorded in the 2014 period primarily related to the loss from early extinguishment of debt recognized in that period and the impact of income tax benefit related to tax basis adjustments for state tax purposes on our acquisition of Vanguard.

NINE MONTHS ENDED SEPTEMBER 30, 2014 COMPARED TO NINE MONTHS ENDED SEPTEMBER 30, 2013

Revenues

During the nine months ended September 30, 2014, same-hospital net operating revenues after provision for doubtful accounts increased 7.7% compared to the nine months ended September 30, 2013, primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts and an increase in our other operations revenues.

Our same-hospital net outpatient revenues and total outpatient visits increased 8.3% and 5.6%, respectively, during the nine months ended September 30, 2014 compared to the same period in 2013. Outpatient revenues and volume growth was primarily driven by improved terms of our managed care contracts, increased outpatient volume levels and our outpatient development program. Net outpatient revenue per visit increased 2.6% primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $866 million and $655 million for the nine months ended September 30, 2014 and 2013, respectively, a portion of which was eliminated in consolidation as described in Note 15 to the Condensed Consolidated Financial Statements. The increase in the portion that was not eliminated in consolidation is primarily due to new clients and expanded service offerings.

Same-hospital patient days increased by 2.5% during the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals as a result of the Affordable Care Act, and a strengthening economy. We believe our inpatient volume levels continue to be constrained by an increase in patients with high-deductible health insurance plans and industry trends reflecting the shift of certain clinical procedures being performed in an outpatient setting rather than an inpatient setting.

Provision for Doubtful Accounts

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.2% and 8.0% for the nine months ended September 30, 2014 and 2013, respectively. The decrease in the provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts primarily related to the decrease in uninsured patient revenues and the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the 130 basis point decrease in our self-pay collection rate, as well as higher patient co-pays and deductibles.

Salaries, Wages and Benefits

Salaries, wages and benefits expense as a percentage of net operating revenues increased 0.1% for the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. Same-hospital salaries, wages and benefits per adjusted patient admission for our hospital operations and other segment increased by approximately 4.0% in the nine months ended September 30, 2014 compared to the same period in 2013. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased incentive compensation expense, an increase in the 401(k) plan maximum matching percentage for certain employee populations and increased health benefits costs. Salaries, wages and benefits expense for the nine months ended September 30, 2014 and 2013 included stock-based compensation expense of $38 million and $27 million, respectively.

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Salaries, wages and benefits expense for Conifer increased by $124 million in the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Supplies

Supplies expense as a percentage of net operating revenues remained flat for the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. Same-hospital supplies expense per adjusted patient admission for our hospital operations and other segment increased by 3.0% in the nine months ended September 30, 2014 compared to the same period in 2013. The change in supplies expense per adjusted patient admission was primarily attributable to higher costs for pharmaceuticals and volume growth in our supply-intensive surgical services.

Other Operating Expenses, Net

Other operating expenses as a percentage of net operating revenues was 25.3% in the nine months ended September 30, 2014 compared to 23.8% in the nine months ended September 30, 2013. Same-hospital other operating expenses per adjusted patient admission for our hospital operations and other segment increased by 5.5% in the nine months ended September 30, 2014 compared to the same period in 2013. The 11.7% increase in same-hospital other operating expenses in the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013 is due to:

- increased costs of contracted services ($28 million);
- higher medical fees primarily related to a greater number of employed and contracted physicians ($44 million);
- increased costs associated with funding indigent care services by certain of our Texas hospitals ($18 million), which were substantially offset by additional net patient revenues;
- increased malpractice expense ($48 million); and
- decreased rent and lease expense ($13 million).

Malpractice expense in the nine months ended September 30, 2014 included isolated unfavorable case reserve adjustments related to a small number of claims, as well as an unfavorable adjustment of approximately $2 million due to a 23 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $8 million as a result of an 84 basis point increase in the interest rate in the 2013 period.

Other operating expenses for Conifer increased by $44 million in the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013 primarily due to higher costs related to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer.

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the nine months ended September 30, 2014, we recorded impairment and restructuring charges and acquisition-related costs of $90 million, consisting of $14 million of employee severance costs, $6 million of contract and lease termination fees, $19 million of restructuring costs, and $51 million in acquisition-related costs, which include $7 million of transaction costs and $44 million of acquisition integration charges.

During the nine months ended September 30, 2013, we recorded impairment and restructuring charges and acquisition-related costs of $45 million, consisting of $2 million relating to the impairment of property, $10 million of restructuring costs, $9 million of employee severance costs, $1 million in lease termination costs, and $23 million in acquisition-related costs.

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Litigation and Investigation Costs

Litigation and investigation costs for the nine months ended September 30, 2014 and 2013 were $19 million and $3 million, respectively, primarily related to costs associated with various legal proceedings and governmental reviews.

Interest Expense

Interest expense for the nine months ended September 30, 2014 was $558 million compared to $292 million for the nine months ended September 30, 2013, primarily due to increased borrowings relating to our recent acquisitions and $400 million of share repurchases during 2013.

Loss from Early Extinguishment of Debt

During the nine months ended September 30, 2014, we recorded a loss from early extinguishment of debt of approximately $24 million, primarily related to the difference between the redemption price and the par value of the $474 million aggregate principal amount of our 9$^{1}/_{4}$% senior notes due 2015 that we redeemed in the period, as well as the write-off of associated unamortized note discounts and issuance costs.

During the nine months ended September 30, 2013, we recorded a loss from early extinguishment of debt of $348 million consisting of $177 million related to the difference between the purchase prices and the par values of the $714 million aggregate principal amount of our $10% senior secured notes due 2018 that we purchased and called during the period, as well as the write-off of associated unamortized note discounts and issuances costs, and $171 million related to the difference between the purchase prices and the par values of the $925 million aggregate principal amount of our 87/8% senior secured notes due 2019 that we purchased and called during the period, as well as the write-off of associated unamortized note discounts and issuance costs.

Income Tax (Benefit) Expense

During the nine months ended September 30, 2014, we recorded income tax benefit of $11 million compared to $57 million during the nine months ended September 30, 2013. The benefit recorded in the 2014 period related

primarily to the loss from early extinguishment of debt recognized in that period and the impact of income tax benefit related to tax basis adjustments for state tax purposes on our acquisition of Vanguard. The benefit recorded in the 2013 period primarily related to the loss from early extinguishment of debt recognized in that period.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

The financial information provided throughout this report, including our Condensed Consolidated Financial Statements and the notes thereto, has been prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). However, we use certain non-GAAP financial measures defined below in communications with investors, analysts, rating agencies, banks and others to assist such parties in understanding the impact of various items on our financial statements, some of which are recurring or involve cash payments. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure that we use in our analysis of the performance of our business, which we define as net income (loss) attributable to our common shareholders before: (1) the cumulative effect of changes in accounting principle, net of tax; (2) net loss (income) attributable to noncontrolling interests; (3) preferred stock dividends; (4) income (loss) from discontinued operations, net of tax; (5) income tax benefit (expense); (6) investment earnings (loss); (7) gain (loss) from early extinguishment of debt; (8) net gain (loss) on sales of investments; (9) interest expense; (10) litigation and investigation benefit (costs), net of insurance recoveries; (11) hurricane insurance recoveries, net of costs; (12) impairment and restructuring charges and acquisition-related costs; and (13) depreciation and amortization. As is the case with all non-GAAP measures, investors should consider the limitations associated with this metric, including the potential lack of comparability of this measure from one company to another, and should recognize that Adjusted EBITDA does not provide a complete measure of our operating performance because it excludes many items that are included in our financial statements. Accordingly, investors are encouraged to use GAAP measures when evaluating our financial performance.

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The table below shows the reconciliation of Adjusted EBITDA to net loss attributable to our common shareholders (the most comparable GAAP term) for the three and nine months ended September 30, 2014 and 2013:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net income (loss) attributable to Tenet Healthcare Corporation common shareholders	$ 9	$ 28	$ (49)	$ (110)
Less: Net (income) attributable to noncontrolling interests	(9)	(8)	(44)	(20)
Loss from discontinued operations, net of tax	(1)	(5)	(22)	(4)
Income (loss) from continuing operations	19	41	17	(86)
Income tax benefit (expense)	18	(16)	11	57
Investment earnings	—	—	—	1
Loss from early extinguishment of debt	(24)	—	(24)	(348)
Interest expense	(186)	(91)	(558)	(292)
Operating income	211	148	588	496
Litigation and investigation costs	(4)	(1)	(19)	(3)
Impairment and restructuring charges, and acquisition-related costs	(37)	(20)	(90)	(45)
Depreciation and amortization	(207)	(119)	(609)	(354)
Adjusted EBITDA	$ 459	$ 288	$ 1,306	$ 898
Net operating revenues	$ 4,179	$ 2,408	$ 12,147	$ 7,217
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	11.0 %	12.0 %	10.8 %	12.4 %

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

There have been no material changes to our obligations to make future cash payments under contracts and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, as disclosed in our Annual Report, except for (i) a $286 million aggregate commitment for a long-term arrangement we entered into during the three months ended June 30, 2014 for future professional services to be provided to us and licensed software fees related to our health information technology initiatives and future ongoing information technology

services for the 28 Vanguard hospitals we acquired in October 2013, and (ii) our recently issued senior notes discussed under the caption “Debt Instruments, Guarantees and Related Covenants” below.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our cash and our operating results. At September 30, 2014, using the last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 6.5x. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including acquisitions that involve the assumption of long-term debt. We intend to manage this ratio by following our business plan, managing our cost structure and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report and the Risk Factors section in Part II of this report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and

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replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements. Capital expenditures were $734 million and $398 million in the nine months ended September 30, 2014 and 2013, respectively. We anticipate that our capital expenditures for continuing operations for the year ending December 31, 2014 will total approximately $900 million to $1 billion, including $193 million that was accrued as a liability at December 31, 2013. Our budgeted 2014 capital expenditures include approximately $18 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree. We expect to spend approximately $18 million more on such improvements over the next two years.

During the nine months ended September 30, 2014, we acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in Sunnyvale, Texas, a suburban community east of Dallas, and completed our acquisition of Emanuel Medical Center, a 209-bed hospital in Turlock, California, located approximately 100 miles southeast of San Francisco. We also acquired four ambulatory surgery centers, three urgent care centers, one diagnostic imaging center and various physician practice entities in the same period. The fair value of the consideration conveyed in the acquisitions was $185 million.

Interest payments, net of capitalized interest, were $487 million and $295 million in the nine months ended September 30, 2014 and 2013, respectively.

Income tax payments, net of tax refunds, were approximately $5 million in each of the nine month periods ended September 30, 2014 and 2013.

SOURCES AND USES OF CASH

Our liquidity for the nine months ended September 30, 2014 was primarily derived from net cash provided by operating activities, cash on hand, issuance of long term debt and borrowings under our revolving credit facility. We had approximately $200 million of cash and cash equivalents on hand at September 30, 2014 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $994 million based on our borrowing base calculation as of September 30, 2014.

Our primary source of operating cash is the collection of accounts receivable. As such, our operating cash flow is impacted by levels of cash collections and levels of bad debt due to shifts in payer mix and other factors.

Net cash provided by operating activities was $468 million in the nine months ended September 30, 2014 compared to $334 million in the nine months ended September 30, 2013. Key positive and negative factors contributing to the

change between the 2014 and 2013 periods include the following:

- Increased income from continuing operations before income taxes of $408 million, excluding loss from early extinguishment of debt, interest expense, investment earnings, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization, in the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013;

- $11 million more cash used in operating activities from discontinued operations;

- An increase of $79 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and

- Higher interest payments of $192 million.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash. These initiatives may include the sale of underutilized or inefficient assets.

Capital expenditures were $734 million and $398 million in the nine months ended September 30, 2014 and 2013, respectively.

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We record our investments that are available-for-sale at fair market value. As shown in Note 13 to the Condensed Consolidated Financial Statements, the majority of our investments are valued based on quoted market prices or other observable inputs. We believe we have no investments that will be negatively affected by the slow economic recovery such that they will materially impact our financial condition, results of operations or cash flows.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

We have a senior secured revolving credit facility (as amended, "Credit Agreement") that provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of November 29, 2016. We are in compliance with all covenants and conditions in our Credit Agreement. At September 30, 2014, we had no cash borrowings outstanding under the revolving credit facility; however, we had approximately $6 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $994 million was available for borrowing under the revolving credit facility at September 30, 2014.

Standby letters of credit are required principally by our insurers and various states to collateralize our workers' compensation programs pursuant to statutory requirements and as security to collateralize the deductible and self-insured retentions under certain of our professional and general liability insurance programs. The amount of collateral required is primarily dependent upon the level of claims activity and our creditworthiness. The insurers require the collateral in case we are unable to meet our obligations to claimants within the deductible or self-insured retention layers. On March 7, 2014, we entered into a new letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our existing Credit Agreement, which we transferred to the LC Facility), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. At September 30, 2014, we had approximately $115 million of standby letters of credit outstanding under the LC Facility.

In September 2014, we sold $500 million aggregate principal amount of 5$^{1}/_{2}$% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, commencing on March 1, 2015. The proceeds from the sale of the notes were used for general corporate purposes, including the repayment of indebtedness and drawings under our Credit Agreement, related transaction fees and expenses, and acquisitions.

In June and March 2014, we sold $500 million and $600 million aggregate principal amount, respectively, of 5% senior notes, which will mature on March 1, 2019. We will pay interest on the notes semi-annually in arrears on March 1 and September 1 of each year, which payments commenced on September 1, 2014. The net proceeds from the sale of the notes in June 2014 were used to redeem our 91/4% senior notes due 2015 in July 2014. The net

proceeds from the sale of the notes in March 2014 were used for general corporate purposes, including the repayment of borrowings under our Credit Agreement. For information regarding our long-term debt and capital lease obligations, see Note 5 to our Condensed Consolidated Financial Statements.

LIQUIDITY

From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time. We believe our existing debt agreements, the significant recent changes to which are described above, provide significant flexibility for future secured or unsecured borrowings.

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest and income tax payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that has caused, and in the future could cause, us to use our senior secured revolving credit facility as a source of liquidity. We believe that existing cash and cash equivalents on hand, availability under our revolving credit facility, anticipated future cash provided by operating activities, and our investments in marketable securities of our captive insurance companies classified as noncurrent investments on our balance sheet should be adequate to meet our current cash needs. These

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sources of liquidity should also be adequate to finance planned capital expenditures and acquisitions, payments on the current portion of our long-term debt and other presently known operating needs.

Long-term liquidity for debt service will be dependent on improved cash provided by operating activities and, given favorable market conditions, future borrowings or refinancings. However, our cash requirements could be materially affected by the use of cash in acquisitions of businesses and repurchases of securities, and also by a deterioration in our results of operations, as well as the various uncertainties discussed in this and other sections of this report, which could require us to pursue any number of financing options, including, but not limited to, additional borrowings, debt refinancings, equity offerings, asset sales or other financing alternatives. The level, if any, of these financing sources cannot be assured.

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our period-end balance sheets. We do not have any significant European sovereign debt exposure.

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are volume growth, including the acquisition and development of outpatient businesses, physician recruitment and alignment strategies, expansion of our services businesses within Conifer, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, underperforming hospitals and health plans, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management peers because of geographic and other differences in hospital portfolios.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the nine months ended September 30, 2014 and 2013 include $345 million and $715 million, respectively, of net operating revenues and $53 million and $93 million, respectively, of operating income generated from general hospitals operated by us under operating lease arrangements (two hospitals as of September 30, 2014 and four hospitals as of September 30, 2013). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet. The current terms of these leases expire in 2027 and 2029. If we are unable to extend these leases or purchase the hospitals, we would no longer generate revenues or expenses from such hospitals.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $248 million of standby letters of credit outstanding and guarantees as of September 30, 2014.

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed Consolidated Financial Statements in conformity with GAAP, we must use estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable, given the particular circumstances in which we operate. Actual results may vary from those estimates.

We consider our critical accounting estimates to be those that (1) involve significant judgments and uncertainties, (2) require estimates that are more difficult for management to determine, and (3) may produce materially different outcomes under different conditions or when using different assumptions.

Our critical accounting estimates have not changed from the description provided in our Annual Report.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments as of September 30, 2014. The fair values were determined based on quoted market prices for the same or similar instruments.

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The average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2014	2015	2016	2017	2018	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 46	$ 87	$ 45	$ 58	$ 1,051	$ 10,287	$ 11,574	$ 11,997
Average effective interest rates	7.0 %	6.3 %	6.5 %	8.5 %	6.6 %	6.7 %	6.7 %	

At September 30, 2014, we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as “special-purpose” or “variable-interest” entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements by us. Thus, we have no exposure to the financing, liquidity, market or credit risks associated with such entities.

We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage or prepayment features.

ITEM 4. CONTROLS AND PROCEDURES

We carried out an evaluation of the effectiveness of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended, as of the end of the period covered by this report. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, the chief executive officer and chief financial officer concluded that, as of the end of the period covered by this report, our disclosure controls and procedures are effective in ensuring that information required to be disclosed in our Securities Exchange Act reports is recorded, processed, summarized and reported in a timely manner and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, to allow timely

decisions regarding required disclosure.

There were no changes in our internal control over financial reporting during the quarter ended September 30, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

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PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 10 to our Condensed Consolidated Financial Statements, which is incorporated by reference. In addition to those matters, as previously disclosed in our Annual Report on Form 10-K for the year ended December 31, 2013 ("Annual Report"), our Conifer Health Solutions, LLC subsidiary ("Conifer") received a Civil Investigative Demand ("CID") in August 2013 from the U.S. Consumer Financial Protection Bureau ("CFPB") that required Conifer to provide to the CFPB a broad range of information regarding its debt collection activities, including its internal compliance procedures. In July 2014, the CFPB issued a second CID seeking information regarding Conifer's compliance with certain notification and other requirements under federal consumer financial laws. Conifer is cooperating with the CFPB in providing the requested information. The CFPB has recently indicated that it currently expects to communicate its conclusions regarding the investigation sometime in the fourth quarter of 2014. If the CFPB determines that a violation of the federal consumer financial laws has occurred, it has the authority to impose fines, require operational changes or take other corrective actions. At this time, because we have not yet met with the CFPB nor has the agency communicated its conclusions regarding the investigation to us, we are unable to predict the outcome of the investigation or provide an estimate of possible range of loss.

ITEM 1A. RISK FACTORS

There have been no material changes to the risk factors discussed in our Annual Report except as set forth below.

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

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

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ITEM 6. EXHIBITS

(4)	Instruments Defining the Rights of Security Holders, Including Indentures	
	(a)	Twenty-Fourth Supplemental Indenture, dated as of September 29, 2014, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as successor trustee to The Bank of New York, relating to 5 1/2% Senior Notes due 2019 (Incorporated by reference to Exhibit 4.2 to Registrant's Current Report on Form 8-K dated and filed September 29, 2014)
(10)	Material Contracts	
	(a)	Exchange and Registration Rights Agreement, dated as of September 29, 2014, between the Registrant and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as representative of the initial purchasers (Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K, dated and filed September 29, 2014)
(31)	Rule 13a-14(a)/15d-14(a) Certifications	
	(a)	Certification of Trevor Fetter, President and Chief Executive Officer
	(b)	Certification of Daniel J. Cancelmi, Chief Financial Officer
(32)	Section 1350 Certification of Trevor Fetter, President and Chief Executive Officer, and Daniel J. Cancelmi, Chief Financial Officer	
(101 INS)	XBRL Instance Document	
(101 SCH)	XBRL Taxonomy Extension Schema Document	
(101 CAL)	XBRL Taxonomy Extension Calculation Linkbase Document	
(101 DEF)	XBRL Taxonomy Extension Definition Linkbase Document	
(101 LAB)	XBRL Taxonomy Extension Label Linkbase Document	
(101 PRE)	XBRL Taxonomy Extension Presentation Linkbase Document	

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: November 3, 2014 By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)