TENET HEALTHCARE CORP
Form 10-K
February 23, 2015
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-K

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

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

Title of each class	Name of each exchange on which registered
Common stock, $0.05 par value	New York Stock Exchange
6 7/8% Senior Notes due 2031	New York Stock Exchange

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

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

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

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

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

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 June 30, 2014, the aggregate market value of the shares of common stock held by non-affiliates of the Registrant (treating directors, executive officers who were SEC reporting persons, and holders of 10% or more of the common stock outstanding as of that date, for this purpose, as affiliates) was approximately $3.9 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 30, 2015, there were 98,494,212 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2015 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

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PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a national, diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks in large urban and suburban markets. At the core of our networks are acute care and specialty hospitals that, together with our strategically aligned outpatient facilities and related businesses, allow us to provide a comprehensive range of healthcare services in the communities we serve. As of December 31, 2014, we operated 80 hospitals, 210 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. On October 1, 2013, we acquired Vanguard Health Systems, Inc. ("Vanguard"), an investor-owned hospital company whose operations complemented our existing business. Through this acquisition, we significantly increased our scale, became more geographically diverse and expanded the services we offer.

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 communications and engagement solutions to optimize the relationship between providers and patients. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. For financial reporting purposes, our business is classified into two separate reportable operating segments — Hospital Operations and other, and Conifer. Financial and statistical information about our business segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

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 in detail in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. In general, we anticipate the continued acceleration of major industry trends we have seen emerge over the last several years, and our strategies reflect the belief that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of a strengthening economy, shifting demographics

and the expansion of coverage under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act" or "ACA"); and (5) payer reimbursements will be constrained and further shift to being more closely tied to performance on quality and service metrics. We believe that our strategies and the acceleration of these trends will allow us to achieve our operational and financial targets; however, 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. Information about risks and uncertainties that could affect our results of operations can be found in "Forward-Looking Statements" below and in Item 1A, Risk Factors, of Part I of this report.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER

Hospitals, Outpatient Centers and Related Businesses—At December 31, 2014, our subsidiaries operated 80 hospitals, including four academic medical centers, two children's hospitals, three specialty hospitals (one of which is temporarily closed for repairs) and a critical access hospital, with a total of 20,814 licensed beds, serving primarily urban and suburban communities in 14 states. Of those hospitals, 74 were owned by our subsidiaries, and six were owned by third parties and leased by our subsidiaries. In addition, at December 31, 2014, our subsidiaries operated a long-term acute care hospital and owned or leased and operated a number of medical office buildings, all of which were located on, or nearby,

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our hospital campuses. Furthermore, our subsidiaries operated 210 free-standing and provider-based outpatient centers in 16 states at December 31, 2014, including diagnostic imaging centers, ambulatory surgery centers, urgent care centers and satellite emergency departments. We also owned over 550 physician practices at December 31, 2014.

We seek to operate our hospitals, outpatient centers and related businesses in a manner that positions them to compete effectively in an evolving healthcare environment. From time to time, we build new hospitals and outpatient centers, and make strategic acquisitions of hospitals, outpatient businesses, physician practices, and other healthcare assets and companies — in each case in markets where we believe our operating strategies can improve performance and create shareholder value. Moreover, we continually evaluate collaboration opportunities with other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum. We believe that growth by strategic acquisitions and partnerships, when and if opportunities are available, can supplement the growth we believe we can generate organically in our existing markets. In furtherance of the foregoing, during the year ended December 31, 2014:

- We opened the newly constructed Resolute Health Hospital in New Braunfels, Texas, which is located northeast of San Antonio. The hospital has 128 beds in all-private rooms, as well as an emergency department, and offers a broad range of specialty care. Resolute Health’s 56-acre wellness campus is designed to draw community members for needs beyond acute healthcare, with services such as a fitness center, health-oriented restaurants, walking trails and an integrative medicine center.

- We acquired a majority interest in Texas Regional Medical Center at Sunnyvale, a 70-bed hospital in a suburban community east of Dallas, and we purchased Emanuel Medical Center, a 209-bed hospital located in Northern California. These comprehensive community hospitals provide services that include emergency, critical care, labor and delivery, cardiology and surgery.

- We opened 27 new outpatient facilities (four diagnostic imaging centers, one ambulatory surgery center, 19 urgent care centers and three stand-alone emergency departments), and we acquired nine other outpatient businesses (one diagnostic imaging center, five ambulatory surgery centers and three urgent care centers), as well as various physician practice entities. Also in 2014, we launched a national brand for our urgent care centers called MedPost Urgent Care.

- 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. Construction on the hospital is expected to be completed in the fall of 2016.

We also sometimes decide to sell, consolidate or close certain facilities to eliminate duplicate services or excess capacity or because of changing market conditions or other factors.

Our hospitals classified in continuing operations for financial reporting purposes generated in excess of 88% of our net operating revenues before provision for doubtful accounts for all periods presented in our Consolidated Financial Statements. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: (1) the business environment, economic conditions and demographics of local communities in which we operate; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local healthcare competitors; (8) managed care contract negotiations or terminations; (9) the number of patients with high-deductible health insurance plans; (10) any unfavorable publicity about us, which impacts our relationships with physicians and patients; (11) changes in healthcare regulations and the participation of individual states in federal programs; and (12) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most offer intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals also offer tertiary care services such as open-heart surgery, neonatal intensive care and neurosciences. Five of our

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hospitals — Good Samaritan Medical Center, Hahnemann University Hospital, Harper University Hospital, North Shore Medical Center and St. Louis University Hospital — offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Children's Hospital of Michigan and St. Christopher's Hospital for Children provide tertiary and quaternary pediatric services, including bone marrow and kidney transplants, as well as burn services. A number of our hospitals also offer advanced treatment options for patients — Good Samaritan Medical Center, North Shore Medical Center, Sierra Medical Center and Sierra Providence East Medical Center offer gamma-knife brain surgery; and Brookwood Medical Center, North Shore Medical Center, Saint Vincent Hospital at Worcester Medical Center and St. Louis University Hospital offer cyberknife radiation therapy for tumors and lesions in the brain, lung, neck, spine and elsewhere that may previously have been considered inoperable or inaccessible by traditional radiation therapy. In addition, our hospitals will continue their efforts to develop and deliver those outpatient services that can be provided on a quality, cost-effective basis and that we believe will meet the needs of the communities served by the facilities.

Many of our hospitals and physician practices also offer a wide range of clinical research studies, giving patients access to innovative care. We are dedicated to helping our hospitals and physicians participate in medical research that is consistent with state and federal regulations and complies with clinical practice guidelines. Clinical research programs relate to a wide array of ailments, including cardiovascular disease, pulmonary disease, musculoskeletal disorders, neurological disorders, genitourinary disease and various cancers, as well as experimental drug and medical device studies. By supporting clinical research, our hospitals are actively involved in medical advancements that can lead to improvements in patient safety and clinical care.

Except as set forth in the table below, each of our acute care hospitals is accredited by The Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs.

The following table lists, by state, the hospitals owned or leased and operated by our subsidiaries as of December 31, 2014:

Hospital	Location	Licensed Beds	Status
Alabama			
Brookwood Medical Center	Birmingham	645	Owned
Arizona			
Arizona Heart Hospital(1)	Phoenix	59	Owned
Arrowhead Hospital	Glendale	217	Owned
Maryvale Hospital	Phoenix	232	Owned

Paradise Valley Hospital	Phoenix	136	Owned
Phoenix Baptist Hospital	Phoenix	221	Owned
West Valley Hospital	Goodyear	188	Owned
California			
Desert Regional Medical Center(2)	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center of Modesto	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
John F. Kennedy Memorial Hospital	Indio	156	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center(3)	San Ramon	123	Owned
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned

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Hospital	Location	Licensed Beds	Status
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
North Shore Medical Center — FMC Campus	Lauderdale Lakes	459	Owned
Palm Beach Gardens Medical Center(4)	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
Saint Mary's Medical Center	West Palm Beach	464	Owned
West Boca Medical Center	Boca Raton	195	Owned
Georgia			
Atlanta Medical Center	Atlanta	762	Owned
Atlanta Medical Center — South Campus(5)	East Point	—	Owned
North Fulton Hospital(6)	Roswell	202	Leased
Spalding Regional Hospital	Griffin	160	Owned
Sylvan Grove Hospital(7)	Jackson	25	Leased
Illinois			
Louis A. Weiss Memorial Hospital	Chicago	236	Owned
MacNeal Hospital	Berwyn	373	Owned
West Suburban Medical Center	Oak Park	234	Owned
Westlake Hospital(8)	Melrose Park	242	Owned
Massachusetts			
MetroWest Medical Center — Framingham Union Hospital	Framingham	147	Owned
MetroWest Medical Center — Leonard Morse Hospital	Natick	138	Owned
Saint Vincent Hospital at Worcester Medical Center	Worcester	283	Owned
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	298	Owned
DMC Surgery Hospital(1)(9)	Madison Heights	67	Owned
Harper University Hospital	Detroit	567	Owned
Huron Valley-Sinai Hospital	Commerce Township	153	Owned
Hutzel Women's Hospital(10)	Detroit	—	Owned
Rehabilitation Institute of Michigan(1)	Detroit	94	Owned
Sinai-Grace Hospital	Detroit	404	Owned
Missouri			
Des Peres Hospital	St. Louis	143	Owned
St. Louis University Hospital	St. Louis	356	Owned
North Carolina			

Central Carolina Hospital	Sanford	137	Owned
Frye Regional Medical Center(11)	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher’s Hospital for Children	Philadelphia	189	Owned

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Hospital	Location	Licensed Beds	Status
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital — Bartlett	Bartlett	196	Owned
Texas			
Baptist Medical Center	San Antonio	623	Owned
Centennial Medical Center	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake	Dallas	218	Owned
Houston Northwest Medical Center(12)	Houston	423	Owned
Lake Pointe Medical Center(13)	Rowlett	112	Owned
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
North Central Baptist Hospital	San Antonio	387	Owned
Northeast Baptist Hospital	San Antonio	379	Owned
Park Plaza Hospital	Houston	444	Owned
Providence Memorial Hospital	El Paso	508	Owned
Resolute Health Hospital	New Braunfels	128	Owned
Sierra Medical Center	El Paso	349	Owned
Sierra Providence East Medical Center	El Paso	170	Owned
St. Luke’s Baptist Hospital	San Antonio	282	Owned
Texas Regional Medical Center at Sunnyvale(14)	Sunnyvale	70	Leased
Valley Baptist Medical Center(15)	Harlingen	586	Owned
Valley Baptist Medical Center — Brownsville(15)	Brownsville	280	Owned
Total Licensed Beds		20,814	

(1)Specialty hospital.
(2)Lease expires in May 2027.
(3)Owned by a limited liability company formed as part of a joint venture with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other healthcare services in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2014, and John Muir Health owned a 49% interest.
(4)Lease expires in February 2017, but may be renewed through at least February 2037, subject to certain conditions contained in the lease.
(5)Licensed beds for Atlanta Medical Center — South Campus are presented on a combined basis with Atlanta Medical Center.

(6)Lease expires in February 2020, but may be renewed through at least February 2040, subject to certain conditions contained in the lease.

(7)Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation. The current lease term for this facility expires in December 2016, but may be renewed through December 2046, subject to certain conditions contained in the lease.

(8)Accredited by the American Osteopathic Association.

(9)Temporarily closed for repairs.

(10)Licensed beds for Hutzel Women's Hospital are presented on a combined basis with Harper University Hospital.

(11)Lease expires in February 2022, but may be renewed through at least February 2042, subject to certain conditions contained in the lease.

(12)Owned by a limited liability company in which a Tenet subsidiary owned an 87.48% interest at December 31, 2014 and is the managing member.

(13)Owned by a limited liability company in which a Tenet subsidiary owned a 94.67% interest at December 31, 2014 and is the managing member.

(14)Leased by a limited liability company in which a Tenet subsidiary owned a 55% interest at December 31, 2014 and is the managing member. The current lease term for this hospital expires in November 2029, but may be renewed through at least November 2049, subject to certain conditions contained in the lease.

(15)At December 31, 2014, Valley Baptist Medical Center and Valley Baptist Medical Center — Brownsville were indirectly owned by a limited liability company formed as part of a joint venture with VB Medical Holdings, a Texas non-profit corporation ("VBMH"); a Tenet subsidiary owned a 51% interest in the limited liability company and was the managing member, and VBMH owned a 49% interest. We subsequently acquired VBMH's 49% interest in the limited liability company pursuant to the terms of the operating agreement governing the joint venture. As a result, we now own 100% of both hospitals as of February 11, 2015.

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The following table presents the number of hospitals operated by our subsidiaries, as well as the total number of licensed beds at those facilities, at December 31, 2014, 2013 and 2012:

	December 31,		
	2014	2013	2012
Total number of hospitals	80	77	49
Total number of licensed beds(1)	20,814	20,293	13,216

(1) Information regarding utilization of licensed beds and other operating statistics can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

As of December 31, 2014, we also owned 210 free-standing and provider-based outpatient centers in 16 states — typically at locations complementary to our hospitals — including 89 diagnostic imaging centers, 54 ambulatory surgery centers, 52 urgent care centers and 15 satellite emergency departments. Most of these outpatient centers are in leased facilities, and a number of outpatient facilities are owned and operated by joint ventures in which we hold a majority equity interest. The largest concentrations of our outpatient centers were in those states where we had the largest concentrations of licensed hospital beds, as of December 31, 2014, as shown in the table below:

	% of Outpatient Centers		% of Licensed Beds	
Texas	33.8	%	26.5	%
California	18.6	%	12.2	%
Florida	12.9	%	16.7	%

Strong concentrations of hospital beds and outpatient centers within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Health Plans and Accountable Care Networks—During the year ended December 31, 2014, we operated six health plans with approximately 100,000 members:

- VHS Phoenix Health Plan, LLC, a Medicaid-managed health plan operating as Phoenix Health Plan ("PHP") in Arizona;

- Phoenix Health Plans, Inc. (formerly known as Abrazo Advantage Health Plan, Inc.), a Medicare and Medicaid dual-eligible managed health plan operating in Arizona;

- Chicago Health System, Inc. ("CHS"), a contracting entity for inpatient and outpatient services provided by MacNeal Hospital, Louis A. Weiss Memorial Hospital and participating physicians in the Chicago area;

- Harbor Health Plan, Inc. (formerly known as ProCare Health Plan, Inc.), a Medicaid-managed health plan operating in Michigan;

- Allegian Insurance Company (formerly known as Valley Baptist Insurance Company), doing business as Allegian Health Plan, which offers health maintenance organization ("HMO"), preferred provider organization ("PPO"), and self-funded products to its members in the form of large group, small group and individual product offerings in south Texas, as well as a Medicare Advantage health plan; and

- Golden State Medicare Health Plan, which is an HMO that specializes in the care of seniors in Southern California who are eligible for benefits under the Medicare Advantage program.

In addition, starting on January 1, 2015, Phoenix Health Plans, Inc., Harbor Health Plan, Inc. and Allegian Insurance Company offer products for individuals on public health insurance exchanges in their respective states.

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We believe these health plans complement and enhance our market position and provide us with expertise that we expect will be increasingly important as the healthcare industry evolves. Specifically, PHP provides us with insights into state initiatives to manage the Arizona Medicaid population, which is valuable in light of the expansion of health coverage to previously uninsured individuals in the state pursuant to the Affordable Care Act and various other healthcare reform laws. In addition, through CHS, our Chicago-based preferred provider network, we manage capitated contracts covering inpatient, outpatient and physician services. We believe our ownership of CHS allows us to gain additional experience with risk-bearing contracts and delivery of care in low-cost settings, including our network of health centers.

We also own or control 11 accountable care networks — in Florida, California, Georgia, Illinois, Michigan, Pennsylvania and Texas — and participate in three additional accountable care networks through collaborations with other healthcare providers in our markets in Arizona, California and Massachusetts. These networks operate using a range of payment and delivery models that seek to align provider reimbursement in a way that encourages improved quality metrics and efficiencies in the total cost of care for an assigned population of patients through cooperation of the providers. We believe that our experience operating health plans and accountable care networks gives us a solid framework upon which to build and expand our population health strategies.

CONIFER

Our Conifer subsidiary provides a number of services primarily to healthcare providers to assist them in generating sustainable improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. At December 31, 2014, Conifer provided one or more of the business process services described below from 25 service centers to approximately 800 Tenet and non-Tenet hospital and other clients in over 40 states.

Revenue Cycle Management—Conifer provides comprehensive operational management for patient access, health information management, revenue integrity and patient financial services, including:

- centralized insurance and benefit verification, financial clearance, pre-certification, registration and check-in services;

- financial counseling services, including reviews of eligibility for government healthcare programs, for both insured and uninsured patients;

- productivity and quality improvement programs, revenue cycle assessments and optimization recommendations, and The Joint Commission and other preparedness services;

- coding and compliance support, billing assistance, auditing, training, and data management services at every step in the revenue cycle process;

- accounts receivable management, third-party billing and collections; and

- ongoing measurement and monitoring of key revenue cycle metrics.

These revenue cycle management solutions assist hospitals and other healthcare organizations in improving cash flow, increasing revenue, and advancing physician and patient satisfaction.

Patient Communications and Engagement Services—Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referrals, calls regarding maternity services and other patient inquiries, (2) community education and outreach, (3) scheduling and appointment reminders, and (4) employee recruitment. Conifer also coordinates and implements mail-based marketing programs to keep patients informed of screenings, seminars and other events and services, as well as conducts patient quality and satisfaction

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surveys to provide valuable feedback to its clients. In addition, Conifer provides clinical admission reviews that are intended to provide evidence-based support for physician decisions on patient status and reduce staffing costs.

Management Services—Conifer also supports value-based performance through clinical integration, financial risk management and population health management, all of which assist hospitals, physicians, accountable care organizations ("ACOs"), health plans, self-insured employers and government agencies in improving the cost and quality of healthcare delivery, as well as patient outcomes. Conifer helps clients build clinically integrated networks that provide predictive analytics and quality measures across the care continuum. In addition, Conifer assists clients in improving both the cost and quality of care by aligning and managing financial incentives among healthcare stakeholders through risk modeling and management for various payment models. Furthermore, Conifer offers clients tools and analytics to improve quality of care and provide care management support for patients with chronic diseases by identifying high-risk patients and monitoring clinical outcomes.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. In May 2012, Conifer entered into a 10-year agreement with Catholic Health Initiatives ("CHI") to provide revenue cycle services for 56 of CHI's hospitals. As part of this initial relationship, CHI received a minority ownership interest in Conifer. In January 2015, Conifer announced a 10-year extension and expansion of its agreement with CHI to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. As further described in Note 22 to our Consolidated Financial Statements, at that time and as a result of CHI's relationship with Tenet, CHI received an increase in its minority ownership position in Conifer. 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.

We began reporting Conifer as a separate operating segment for financial reporting purposes in the three months ended June 30, 2012. The loss of Conifer's key customers, primarily Tenet and CHI, in the future could have a material adverse impact on the segment; however, CHI is not a key customer to Tenet on a consolidated basis. Financial and other information about our Conifer operating segment is provided in the Consolidated Financial Statements included in this report.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2014 are set forth in the table beginning on page 3. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own nearly all of our medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

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

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright, patent and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. However, third parties may develop intellectual property that is similar or superior to ours. Conversely, although we do not believe the intellectual property we utilize infringes any intellectual property right held by a third party, we could be prevented from utilizing such property and could be subject to significant damage awards if it is found to do so.

We control access to and the use of our application capabilities through a combination of internal and external controls. We also license some of our software through agreements that impose specific restrictions on customers' ability to use the software, such as prohibiting reverse engineering and limiting the use of copies.

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We incorporate third-party commercial and, on occasion, open source software products into our technology platform. We employ third-party licensed software in order to simplify our development and maintenance efforts, support our own technology infrastructure or test a new capability.

MEDICAL STAFF AND EMPLOYEES

Medical Staff—Our operations depend in significant part on the number, quality and specialties of the licensed physicians who have been admitted to the medical staffs of our hospitals, the admitting practices of those physicians and maintaining good relations with those physicians. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by the hospital's local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of hospitals we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing hospitals at any time. As of December 31, 2014, we owned over 550 physician practices, and we employed (where permitted by state law) or otherwise affiliated with approximately 2,000 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals. It is essential to our ongoing business that we attract and retain on our medical staffs an appropriate number of quality physicians in the specialties required to support our services. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance.

Employees—As of December 31, 2014, we employed over 108,000 people (of which 23% were part-time employees) in the following categories:

Hospital operations(1)	95,050
Conifer	12,099
Administrative offices	1,840
Total	108,989

(1) Includes employees at our general hospitals, specialty hospitals, critical access hospital, long-term acute care hospital, outpatient centers, physician practices, health plans, accountable care networks and other healthcare operations.

We are subject to federal minimum wage and hour laws and various state labor laws, and maintain a number of different employee benefit plans.

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

Union Activity and Labor Relations—As of December 31, 2014, approximately 20% of our employees were represented by labor unions. These employees — primarily registered nurses and service and maintenance workers — are located at 38 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six 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.

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Mandatory Nurse-Staffing Ratios—At this time, California is the only state in which we operate that requires minimum nurse-to-patient staffing ratios to be maintained at all times in acute care hospitals. If other states in which we operate adopt mandatory nurse-staffing ratios or if California reduces its minimum nurse-staffing ratios already in place, it could have a significant effect on our labor costs and have an adverse impact on our net operating revenues if we are required to limit patient admissions in order to meet the required ratios.

COMPETITION

HEALTHCARE SERVICES

Our hospitals, outpatient centers and other healthcare businesses operate in competitive environments, primarily at the local level. Generally, other hospitals and outpatient centers in the local communities we serve provide services similar to those we offer, and, in some cases, competing facilities are more established or newer than ours. Furthermore, competing facilities (1) may offer a broader array of services to patients and physicians than ours, (2) may have larger or more specialized medical staffs to admit and refer patients, (3) may have a better reputation in the community, or (4) may be more centrally located with better parking or closer proximity to public transportation. In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies in specific geographic markets.

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

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

State laws that require findings of need for construction and expansion of healthcare facilities or services (as described in “Healthcare Regulation and Licensing — Certificate of Need Requirements” below) may also have the effect of restricting competition. In addition, in those states that do not have certificate of need requirements or that do not require review of healthcare capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

Our strategies are designed to help our hospitals and outpatient facilities remain competitive. We have targeted capital spending on critical growth opportunities, with an emphasis on higher-demand clinical service lines, which is expected to have a positive impact on volumes. We have also sought to include all of our hospitals and other healthcare businesses in the related geographic area or nationally when negotiating new managed care contracts, which may result in additional volumes at facilities that were not previously a part of such managed care networks. Moreover, we have continued to expand our outpatient business, and we have increased our focus on operating our outpatient centers with improved accessibility and more convenient service for patients, as well as increased predictability and efficiency for physicians.

We have also 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

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efforts, our CMS Hospital Compare Core Measures scores 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. 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 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.

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. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Further, each hospital has a local governing board, consisting primarily of community members and physicians, that develops short-term and long-term plans for the hospital to foster a desirable medical environment. Each local governing board also reviews and approves, as appropriate, actions of the medical staff, including staff appointments, credentialing, peer review and quality assurance. While physicians may terminate their association with our hospitals at any time, we believe that by striving to maintain and improve the quality of care at our hospitals and by maintaining ethical and professional standards, we will attract and retain qualified physicians with a variety of specialties.

REVENUE CYCLE MANAGEMENT SOLUTIONS

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

- software vendors and other technology-supported revenue cycle management business process outsourcing companies;

- traditional consultants, either specialized healthcare consulting firms or healthcare divisions of large accounting firms; and

- large, non-healthcare focused business process and information technology outsourcing firms.

We believe that competition for the revenue cycle management and other services Conifer provides is based primarily on: (1) knowledge and understanding of the complex public and private healthcare payment and reimbursement systems; (2) a track record of delivering revenue improvements and efficiency gains for hospitals and other healthcare providers; (3) the ability to deliver solutions that are fully integrated along each step of the revenue cycle; (4) cost-effectiveness, including the breakdown between up-front costs and pay-for-performance incentive compensation; (5) reliability, simplicity and flexibility of the technology platform; (6) understanding of the healthcare industry's regulatory environment; (7) sufficient infrastructure; and (8) financial stability.

To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential

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customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

HEALTHCARE REGULATION AND LICENSING

AFFORDABLE CARE ACT

The Affordable Care Act is changing how healthcare services in the United States are covered, delivered and reimbursed. The primary goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. To fund the expansion of insurance coverage, the legislation contains measures designed to promote quality and cost efficiency in healthcare delivery and to generate budgetary savings in the Medicare and Medicaid programs. In addition, the ACA contains provisions intended to strengthen fraud and abuse enforcement.

Health Insurance Market Reforms—One key provision of the Affordable Care Act is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. 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 penalty percentage increases through 2016 and is adjusted for inflation beginning in 2017. 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. Health insurance exchanges are government-regulated organizations that provide competitive markets for buying health insurance by offering individuals and small employers a choice of different health plans, certifying plans that participate, and providing information to help consumers better understand their options. Some states operate their own exchanges; in most states, however, individuals must utilize the federal government's health insurance exchange found online at HealthCare.gov. Under the Affordable Care Act, individuals who are enrolled in a health benefits plan purchased through an exchange may be eligible for a premium credit or cost-sharing subsidy. In 2014, two federal appeals court panels issued conflicting rulings on whether U.S. Internal Revenue Service ("IRS") regulations extending such subsidies to individuals who purchase coverage through the federal government's health insurance exchange (rather than a state-based exchange) are permissible. The U.S. Supreme Court will now consider the matter, and a ruling is expected in mid-2015. Pending the Supreme Court's decision on the issue, the government has stated that it will continue paying the subsidies to insurance companies on behalf of consumers in the 34 states that use the federal exchange. As of December 31, 2014, we operated hospitals in two states that run their own health insurance exchanges and 12 states that rely on the federal exchange.

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. In February 2014, the requirements of the

employer mandate were further delayed until January 1, 2016. Based on the U.S. Congressional Budget Office's most recent estimates, we do not believe that the delays in enforcement of the employer mandate will have a discernible effect on insurance coverage.

The Affordable Care Act also establishes a number of health insurance market reforms, including bans on lifetime limits and pre-existing condition exclusions, new benefit mandates, and increased dependent coverage. Specifically, group health plans and health insurance issuers offering group or individual coverage:

- may not establish lifetime or annual limits on the dollar value of benefits;

- may not rescind coverage of an enrollee, except in instances where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact;

- must reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place; and

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- must continue to make dependent coverage available to unmarried dependents until age 26 (coverage for the dependents of unmarried adult children is not required) effective for health plan policy years beginning on or after September 23, 2010 (for plans that offer dependent coverage).

Public Program Reforms—Another key provision of the Affordable Care Act 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 Affordable Care Act, 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 requires state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. There is no deadline for a state to undertake expansion and qualify for the enhanced federal funding available under the Affordable Care Act. As of December 31, 2014, we operated hospitals in five of the states (Arizona, California, Illinois, Massachusetts and Michigan) that expanded their Medicaid programs in 2014 and one of the states (Pennsylvania) 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 or whether those states that do expand their Medicaid programs will continue to offer expanded eligibility in the future.

The Affordable Care Act also provides that the federal government will subsidize states that create non-Medicaid plans called “Basic Health Programs” for residents whose incomes are greater than 133% but less than 200% of the federal poverty level. Approved state plans will be eligible to receive federal funding, however, CMS announced in February 2013 that Basic Health Programs would not be operational until 2015.

Even though the Affordable Care Act expanded Medicaid eligibility, the law also contains a number of provisions designed to significantly reduce Medicare and Medicaid program spending, including:

- negative adjustments to the annual input price index, or “market basket,” updates for Medicare’s 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

- reductions to Medicare and Medicaid disproportionate share hospital (“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.

The Affordable Care Act also contains a number of provisions intended to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. For example, the legislation expands payment penalties based on a hospital’s rates of certain Medicare-designated hospital-acquired conditions (“HACs”). These HACs, which would normally result in a higher payment for an inpatient hospital discharge, will instead be paid as

though the HAC is not present. The ACA likewise prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. Currently, hospitals with excessive readmissions for certain conditions receive reduced Medicare payments for all inpatient admissions. Beginning in FFY 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year also receive a 1% reduction in Medicare payment rates. Separately, under a Medicare value-based purchasing program that was launched in FFY 2013, hospitals that satisfy certain performance standards receive increased payments for discharges during the following fiscal year. These payments are funded by decreases in payments to all hospitals for inpatient services. For discharges occurring during FFY 2014 and after, the performance standards must assess hospital efficiency, including Medicare spending per beneficiary. In addition, the Affordable Care Act directed CMS to launch a national pilot program to study the use of bundled payments to hospitals, physicians and post-acute care providers relating to a single admission to promote collaboration and alignment on quality and efficiency improvement; the pilot program is currently ongoing through the Center for Medicare and Medicaid Innovation within CMS, which has the authority to develop and test new payment methodologies designed to improve quality of care and lower costs.

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Furthermore, the Affordable Care Act contains provisions relating to recovery audit contractors ("RACs"), which are third-party organizations under contract with CMS that identify underpayments and overpayments under the Medicare program and recoup any overpayments on behalf of the government. The Affordable Care Act expanded the RAC program's scope to include Medicaid claims and required all states to enter into contracts with RACs.

Other Provisions—The Affordable Care Act contains a number of other additional provisions, including provisions relating to the Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments, Section 1877 of the Social Security Act (commonly referred to as the "Stark" law), and qui tam or "whistleblower" actions, each of which is described in detail below, as well as provisions regarding:

- the creation of an Independent Payment Advisory Board that will make recommendations to Congress regarding additional changes to provider payments and other aspects of the nation's healthcare system; and

- new taxes on manufacturers and distributors of pharmaceuticals and medical devices used by our hospitals, as well as a requirement that manufacturers file annual reports of payments made to physicians.

The Impact of Health Reform on Us—As further discussed in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report, the expansion of health insurance coverage under the Affordable Care Act has resulted in a material increase in the number of patients using our facilities who have either private or public program coverage and a material decrease in uninsured and charity care admissions. Further, the ACA provides for a value-based purchasing program, the establishment of ACOs and bundled payment pilot programs, which created possible additional sources of revenue for our company. However, it remains difficult to predict the full impact of the Affordable Care Act on our future revenues and operations at this time due to uncertainty regarding a number of material factors, including:

- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);
- how many currently uninsured individuals will ultimately obtain coverage (either private health insurance or Medicaid) as a result of the Affordable Care Act;

- what percentage of our newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;

- the extent to which states will enroll new Medicaid participants in managed care programs;

- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;

- future changes in the rates paid to hospitals by private payers for newly covered individuals, including those covered through health insurance exchanges and those who might be covered under the Medicaid program under contracts with a state;

- future changes in the rates paid by state governments under the Medicaid program for newly covered individuals;

- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals; and

- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

In addition, the Affordable Care Act continues to be subject to possible delays, revisions and even elimination as a result of court challenges and actions by Congress. Any ruling or other action that negatively impacts the number of

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individuals who have health insurance coverage could have a material adverse effect on our results of operations and cash flows.

Furthermore, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. Any reductions to our reimbursement under the Medicare and Medicaid programs pursuant to the ACA could adversely affect our business and results of operations to the extent such reductions are not offset by increased revenues from providing care to previously uninsured individuals. It is difficult to predict the future effect on our revenues resulting from reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are fully implemented;
- whether future reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;
- the size of the annual productivity adjustment to the market basket;
- the reductions to Medicaid DSH payments commencing in FFY 2017;
- what the losses in revenues, if any, will be from the ACA’s quality initiatives;
- how successful accountable care networks in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for “excessive readmissions.”

In addition, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care for persons living in the country illegally who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

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 individuals who will obtain and retain 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.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

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

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Act amended the Anti-kickback Statute to provide that knowledge of the law or the intent to violate the law is not required.

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

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

Stark Law—The Stark law generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined "designated health services," such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services. The exceptions to the referral prohibition cover a broad range of common financial relationships. These statutory and the subsequent regulatory exceptions are available to protect certain permitted employment relationships, relocation arrangements, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark Law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

The Affordable Care Act also made changes to the "whole hospital" exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in existing physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital had physician ownership and a Medicare provider agreement as of March 23, 2010 (or, for those hospitals under development at the time of the ACA's enactment, as of December 31, 2010). A physician-owned hospital that meets these requirements is still subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for hospitals with a high percentage of Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. The legislation also subjects a physician-owned hospital to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements. As of December 31, 2014, three of our hospitals are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals.

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Implications of Fraud and Abuse Laws—Our operations could be adversely affected by the failure of our arrangements to comply with the Anti-Kickback Statute, the Stark Law, billing laws and regulations, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. We are continuing to enter into new financial arrangements with physicians and other providers in a manner structured to comply in all material respects with these laws. We cannot assure you, however, that governmental officials responsible for enforcing these laws will not assert that we are in violation of them or that such statutes or regulations ultimately will be interpreted by the courts in a manner consistent with our interpretation.

We have a variety of financial relationships with physicians who refer patients to our hospitals, and we may sell ownership interests in certain of our other facilities to physicians and other qualified investors in the future. We also have contracts with physicians providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements. We have provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

In accordance with our ethics and compliance program, which is described in detail under “Compliance and Ethics” below, we have policies and procedures in place concerning compliance with the Anti-kickback Statute and the Stark law, among others. In addition, our ethics and compliance, law and audit services departments systematically review a substantial number of our arrangements with referral sources to determine the extent to which they comply with our policies and procedures and with the Anti-kickback Statute, the Stark law and similar state statutes. On the one hand, we may be less willing than some of our competitors to take actions or enter into business arrangements that do not clearly satisfy the safe harbors and exceptions to the fraud and abuse laws described above; as a result, this unwillingness may put us at a competitive disadvantage. On the other hand, we cannot assure you that the regulatory authorities that enforce these laws will not determine that some of our arrangements violate the Anti-Kickback Statute, the Stark law or other applicable regulations. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal healthcare programs, any of which could have a material adverse effect on our business, financial condition or results of operations. In addition, any determination by a federal or state agency or court that we have violated any of these laws could give Conifer’s customers the right to terminate our services agreements with them. Moreover, any violations by and resulting penalties or exclusions imposed upon Conifer’s customers could adversely affect their financial condition and, in turn, have a material adverse effect on Conifer’s business and results of operations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Title II, Subtitle F of the Health Insurance Portability and Accountability Act mandates the adoption of specific standards for electronic transactions and code sets that are used to transmit certain types of health information.

HIPAA's objective is to encourage efficiency and reduce the cost of operations within the healthcare industry. To protect the information transmitted using the mandated standards and the patient information used in the daily operations of a covered entity, HIPAA also sets forth federal rules protecting the privacy and security of protected health information ("PHI"). The privacy and security regulations address the use and disclosure of individually identifiable health information and the rights of patients to understand and control how their information is used and disclosed. The law provides both criminal and civil fines and penalties for covered entities that fail to comply with HIPAA.

To receive reimbursement from CMS for electronic claims, healthcare providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain healthcare information electronically. Our electronic data transmissions are compliant with current standards. In January 2009, CMS published a final rule changing the formats used for certain electronic transactions and requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. At this time, use of the ICD-10 code sets is not mandatory until October 1, 2015. We are continuing to modify our payment systems and processes to prepare

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for ICD-10 implementation. Although use of the ICD-10 code sets will require significant administrative changes, we believe that the cost of compliance with these regulations has not had and is not expected to have a material adverse effect on our business, financial condition, results of operations or revenues. However, we may experience a short-term adverse impact on our cash flows due to claims processing delays related to implementation of the new code sets by payers and us. Furthermore, the Affordable Care Act required the U.S. Department of Health and Human Services ("HHS") to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

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

In 2009, HIPAA was amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act to impose certain of the HIPAA privacy and security requirements directly upon business associates of covered entities and significantly increase the monetary penalties for violations of HIPAA. Regulations that took effect in late 2009 also require business associates such as Conifer to notify covered entities, who in turn must notify affected individuals and government authorities, of data security breaches involving unsecured PHI. Since the passage of the HITECH Act, enforcement of HIPAA violations has increased. A knowing breach of the HIPAA privacy and security requirements made applicable to business associates by the HITECH Act could expose Conifer to criminal liability, and a breach of safeguards and processes that is not due to reasonable cause or involves willful neglect could expose Conifer to significant civil penalties and the possibility of civil litigation under HIPAA and applicable state law.

In May 2011, the Office for Civil Rights of HHS proposed new regulations to implement changes to the HIPAA requirements set forth in the HITECH Act that state that covered entities and business associates must account for disclosures of PHI to carry out treatment, payment and healthcare operations if such disclosures are through an electronic health record. The proposed regulations seek to expand the scope of the requirements under the HITECH Act and create a new patient right to an "access report," which would be required to list every person who has accessed, for any reason, PHI about the individual contained in any electronic designated record set. Because our hospitals currently utilize multiple, independent modules that may meet the definition of "electronic designated record set," our ability to produce an access report that satisfies the proposed regulatory requirements would likely require new technology solutions to map across those multiple record sets. It is our understanding that many providers have expressed significant concerns to CMS regarding the access report requirement created by the proposed rule. In January 2013, HHS issued final regulations modifying the requirements set forth in the HITECH Act. While we were in material compliance with the new regulations as of the compliance date of September 23, 2013, the new regulations did not address the proposed "access report" requirement. Because we cannot predict the requirements of any future final rule regarding access reports, we are unable to estimate the costs of compliance, if any, at this time.

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

HEALTH PLAN REGULATORY MATTERS

Our health plans are subject to numerous federal and state laws and regulations related to their business operations, including, but not limited to: the form and content of member contracts, including certain mandated benefits;

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premium rates and medical loss ratios; the content of agreements with participating providers; claims processing and appeals; underwriting practices; reinsurance arrangements; protecting the privacy and confidentiality of the information received from members; risk-sharing arrangements with providers; the quality of care provided to beneficiaries; reimbursement or payment levels for Medicare services; the provision of products or services to employer-sponsored health benefit plans; the expansion into new service areas; participation on the health insurance exchanges; the award, administration and performance of federal contracts; the administration of strategic alliances with competitors, including information sharing; and advertising, marketing and sales activities.

Each of our health plans must also be licensed by one or more agencies in the states in which they conduct business and must submit periodic filings to and respond to inquiries from such agencies. State insurance regulators may require expanded governance practices, periodic risk and solvency assessment reports, and the establishment of minimum capital or restricted cash reserve requirements. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. Furthermore, our health plan operations, accounts, and other books and records are subject to examination at regular intervals by regulatory agencies, including CMS and state insurance and health and welfare departments, to assess their compliance with applicable laws and regulations. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with the laws, rules and regulations affecting our health plans, if a determination is made that we were in violation of such laws, rules or regulations with respect to one or more of our health plans, that aspect of our business could be materially adversely affected.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the healthcare industry. The operational mission of the Office of Inspector General (“OIG”) of HHS is to protect the integrity of the Medicare and Medicaid programs and the well-being of program beneficiaries by: detecting and preventing waste, fraud and abuse; identifying opportunities to improve program economy, efficiency and effectiveness; and holding accountable those who do not meet program requirements or who violate federal laws. The OIG carries out its mission by conducting audits, evaluations and investigations and, when appropriate, imposing civil monetary penalties, assessments and administrative sanctions. Although we have extensive policies and procedures in place to facilitate compliance in all material respects with the laws, rules and regulations affecting the healthcare industry, if a determination is made that we were in violation of such laws, rules or regulations, our business, financial condition, results of operations or cash flows could be materially adversely affected.

Healthcare providers are also subject to qui tam or “whistleblower” lawsuits under the federal False Claims Act, which allows private individuals to bring actions on behalf of the government, alleging that a hospital or healthcare provider has defrauded a government program, such as Medicare or Medicaid. If the government intervenes in the action and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties for each false claim submitted to the government. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment. If the government does not intervene in the action, the qui tam plaintiff may continue to pursue the action independently. There are many

potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term “knowingly” broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a “knowing” submission under the FCA and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Affordable Care Act, the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, constitutes a violation of the FCA. Further, the Affordable Care Act expands the scope of the FCA to cover payments in connection with health insurance exchanges if those payments include any federal funds. Qui tam actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies. Like other companies in the healthcare industry, we are subject to qui tam actions from time to time. We are unable to predict the future impact of such actions on our business, financial condition, results of operations or cash flows.

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HEALTHCARE FACILITY LICENSING REQUIREMENTS

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

UTILIZATION REVIEW COMPLIANCE AND HOSPITAL GOVERNANCE

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

There has been recent increased scrutiny of hospitals’ Medicare observation rates from outside auditors, government enforcement agencies and industry observers. The term “Medicare observation rate” is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In our affiliated hospitals, we use the independent, evidence-based clinical criteria developed by McKesson Corporation, commonly known as InterQual Criteria, to determine whether a patient qualifies for inpatient admission. The industry anticipates increased scrutiny and litigation risk, including government investigations and qui tam suits, related to inpatient admission decisions and the Medicare observation rate. In addition, effective October 1, 2013, CMS established a new concept, referred to as the “two-midnight rule,” to guide practitioners admitting patients and contractors conducting payment reviews on when it is appropriate to admit

individuals as hospital inpatients. Under the two-midnight rule, CMS has indicated that a Medicare patient should generally be admitted on an inpatient basis only when there is a reasonable expectation that the patient's care will cross two midnights, and, if not, then the patient generally should be treated as an outpatient. Our hospitals have undertaken extensive efforts to implement the two-midnight rule in light of existing guidance. CMS is currently conducting a "probe and educate" program regarding the two-midnight rule, the purpose of which is to assess hospitals' compliance with the rule and also to provide follow-up education. The probe and educate period is currently scheduled to end March 31, 2015 and, unless extended, full implementation and enforcement of the two-midnight rule will begin on April 1, 2015. Although the probe and educate program is still ongoing, we do not believe enforcement of the two-midnight rule will have a material impact on inpatient admission rates at our hospitals.

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

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enforce practices and procedures, as well as approves the credentials, disciplining and, if necessary, the termination of privileges of medical staff members.

CERTIFICATE OF NEED REQUIREMENTS

Some states require state approval for construction, acquisition and closure of healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates or determinations of need, which are issued by governmental agencies with jurisdiction over healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. As of December 31, 2014, we operated hospitals in 10 states that require a form of state approval under certificate of need programs applicable to those hospitals. Failure to obtain necessary state approval can result in the inability to expand facilities, add services, acquire a facility or change ownership. Further, violation of such laws may result in the imposition of civil sanctions or the revocation of a facility's license. We are unable to predict whether we will be required or able to obtain any additional certificates of need in any jurisdiction where they are required, or if any jurisdiction will eliminate or alter its certificate of need requirements in a manner that will increase competition and, thereby, affect our competitive position. In those states that do not have certificate of need requirements or that do not require review of healthcare capital expenditure amounts below a relatively high threshold, competition in the form of new services, facilities and capital spending is more prevalent.

ENVIRONMENTAL MATTERS

Our healthcare operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with laws and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws and regulations, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows.

Consistent with our commitment to meet the highest standards of corporate responsibility, we have formed a sustainability committee consisting of corporate and hospital leaders to regularly evaluate our environmental outcomes and share best practices among our hospitals and other facilities. In 2014, we published our fourth annual sustainability report, using the industry-standard Global Reporting Initiative framework. In addition, we are a sponsor

of the Healthier Hospitals Initiative and continue to work with each of our hospitals in adopting components of the initiative's agenda, which focuses on improvements in (1) sustainability governance, (2) the provision of healthier foods, (3) energy consumption, (4) waste generation, (5) the use of safer chemicals and (6) purchasing decisions. We are committed to report the results of our sustainability efforts on an annual basis.

ANTITRUST LAWS

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

Antitrust enforcement in the healthcare industry is currently a priority of the U.S. Federal Trade Commission ("FTC"). In recent years, the FTC has filed multiple administrative complaints challenging hospital transactions in

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several states. The FTC has focused its enforcement efforts on preventing hospital mergers that may, in the government's view, leave insufficient local options for inpatient services. In addition to hospital merger enforcement, the FTC has given increased attention to the effect of combinations involving other healthcare providers, including physician practices. The FTC has also entered into numerous consent decrees in the past several years settling allegations of price-fixing among providers.

We believe we are in compliance with federal and state antitrust laws, but there can be no assurance that a review of our practices by courts or regulatory authorities would not result in a determination that could adversely affect our operations.

REGULATIONS AFFECTING CONIFER'S OPERATIONS

As described below, Conifer and certain of its subsidiaries are subject to laws, rules and regulations regarding their consumer finance, debt collection and credit reporting activities.

DEBT COLLECTION ACTIVITIES

The federal Fair Debt Collection Practices Act ("FDCPA") regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of the accounts receivable handled by Conifer's debt collection agency subsidiary, Syndicated Office Systems, LLC ("SOS"), are subject to the FDCPA, which establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. Further, the FDCPA prohibits harassment or abuse by debt collectors, including the threat of violence or criminal prosecution, obscene language or repeated telephone calls made with the intent to abuse or harass. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt and sets forth specific procedures to be followed when communicating with such third parties for purposes of obtaining location information about the consumer. In addition, the FDCPA contains various notice and disclosure requirements and prohibits unfair or misleading representations by debt collectors. Finally, the FDCPA imposes certain limitations on lawsuits to collect debts against consumers. Debt collection activities are also regulated at the state level. Most states have laws regulating debt collection activities in ways that are similar to, and in some cases more stringent than, the FDCPA.

Many states also regulate the collection practices of creditors who collect their own debt. These state regulations are often the same or similar to state regulations applicable to third-party collectors. Certain of the accounts receivable Conifer handles are subject to these state regulations.

In certain situations, the activities of SOS are also subject to the Fair Credit Reporting Act ("FCRA"). The FCRA regulates the collection, dissemination and use of consumer information, including consumer credit information. In addition, the FCRA requires Conifer to promptly update any credit information it has reported to a credit reporting agency about a consumer and to allow a process by which consumers may inquire about such information. The FCRA may impose liability on us to the extent that adverse credit information reported on a consumer to a credit bureau is false or inaccurate. State law, to the extent it is not preempted by the FCRA, may also impose restrictions or liability on SOS with respect to reporting adverse credit information that is false or inaccurate.

The federal Fair and Accurate Credit Transaction Act ("FACTA") requires Conifer to adopt (1) written guidance and procedures for detecting, preventing and responding appropriately to mitigate identity theft, and (2) coworker policies and procedures (including training) that address the importance of protecting non-public personal information and aid Conifer in detecting and responding to suspicious activity, including suspicious activity that may suggest a possible identity theft red flag, as appropriate. Furthermore, Conifer is subject to regulation by the Federal Trade Commission. The FTC's Bureau of Consumer Protection works to protect consumers against unfair, deceptive or fraudulent practices in the marketplace. In furtherance of consumer protection, the FTC provides guidance and enforces federal laws concerning truthful advertising and marketing practices, fair financial practices and debt collection, and protection of sensitive consumer information.

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The U.S. Consumer Financial Protection Bureau (“CFPB”) and the FTC have the authority to investigate consumer complaints relating to the FDCPA, FCRA and FACTA, and to initiate enforcement actions, including actions to seek restitution and monetary penalties. State officials typically have authority to enforce corresponding state laws. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

The CFPB was formed within the U.S. Federal Reserve pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act (the “Dodd-Frank Act”) 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. In 2013, the CFPB issued examination procedures for, and began conducting examinations of, a number of companies with respect to their debt collection practices. The CFPB’s examination and overall enforcement authority permits agency examiners to inspect the books and records of companies engaged in debt collection activities, such as SOS, and ask questions about their payment processing activities, collections, accounts in default, consumer reporting and third-party relationships, as well as compliance programs. We believe that the potential exists that non-bank providers of consumer credit that are examined by the CFPB could, depending upon the circumstances, be required, as a result of any CFPB examination, to change their practices or procedures. In addition, 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. In general, we believe that the CFPB regulatory and enforcement processes will have a significant impact on the operations of Conifer and its subsidiaries.

PAYMENT ACTIVITY RISKS

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

COMPLIANCE AND ETHICS

General—Our ethics and compliance department maintains our multi-faceted, values-based ethics and compliance program, which is designed to (1) help staff in our corporate and Conifer offices, hospitals, outpatient centers, health plan offices and physician practices meet or exceed applicable standards established by federal and state laws and regulations, as well as industry practice, and (2) monitor and raise awareness of ethical issues among employees and others, and stress the importance of understanding and complying with our Standards of Conduct. The ethics and compliance department operates with independence — it has its own operating budget; it has the authority to hire outside counsel, access any Tenet document and interview any of our personnel; and our chief compliance officer reports directly to the quality, compliance and ethics committee of our board of directors.

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

· support and maintain our present and future responsibilities with regard to participation in federal healthcare programs; and

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

The primary focus of our quality, compliance and ethics program is compliance with the requirements of Medicare, Medicaid and other federally funded healthcare programs. Pursuant to the terms of the charter, our ethics and compliance department is responsible for the following activities: (1) annually assessing, critiquing and (as appropriate) drafting and distributing company policies and procedures; (2) developing, providing and tracking ethics training for all employees, directors and, as applicable, contractors and agents; (3) developing, providing and tracking job-specific training to those who work in clinical quality, coding, billing, cost reporting and referral source arrangements; (4) developing, providing and tracking annual training on ethics and clinical quality oversight to the members of each hospital governing board; (5) creating and disseminating the company's Standards of Conduct and obtaining certifications of adherence to the Standards of Conduct as a condition of employment; (6) maintaining and promoting Tenet's Ethics Action Line, which allows confidential reporting of issues on an anonymous basis and emphasizes Tenet's no retaliation policy; (7) responding to and resolving all compliance-related issues that arise from the Ethics Action Line and compliance reports received from our facilities, hospital compliance officers or any other source; (8) ensuring that appropriate corrective and disciplinary actions are taken when non-compliant conduct or improper contractual relationships are identified; (9) monitoring and measuring adherence to all applicable Tenet policies and legal and regulatory requirements related to federal healthcare programs; (10) directing an annual screening of individuals for exclusion from federal healthcare program participation as required by federal regulations; (11) maintaining a database of all arrangements involving the payment of anything of value between Tenet and any physician or other actual or potential source of healthcare business or referrals to or from Tenet; and (12) overseeing annual audits of clinical quality, referral source arrangements, outliers, charging, coding, billing and other compliance risk areas as may be identified from time to time.

Standards of Conduct—All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our Standards of Conduct to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and many of our contractors are also required to abide by our Standards of Conduct. The standards reflect our basic values and form the foundation of a comprehensive process that includes compliance with all corporate policies, procedures and practices. Our standards cover such areas as quality patient care, compliance with all applicable laws and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

As part of the program, we provide annual training sessions to every employee, as well as our board of directors and certain physicians and contractors. All employees are required to report incidents that they believe in good faith may be in violation of the Standards of Conduct, and are encouraged to contact our 24-hour toll-free Ethics Action Line when they have questions about the standards or any ethics concerns. All reports to the Ethics Action Line are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. Incidents of alleged financial improprieties reported to the Ethics Action Line or the ethics and compliance department are communicated to the audit committee of our board of directors. Reported cases that involve a possible violation of the law or regulatory policies and procedures are referred to the ethics and compliance department for investigation. Retaliation against employees in connection with reporting ethical concerns is considered a serious violation of our Standards of

Conduct, and, if it occurs, it will result in discipline, up to and including termination of employment.

Availability of Documents—The full text of our Quality, Compliance and Ethics Program Charter, our Standards of Conduct, and a number of our ethics and compliance policies and procedures are published on our website, at www.tenethealth.com, under the “Ethics and Compliance” caption in the “About” section. A copy of our Standards of Conduct is also available upon written request to our corporate secretary. Information about how to contact our corporate secretary is set forth under “Company Information” below. Amendments to the Standards of Conduct and any grant of a waiver from a provision of the Standards of Conduct requiring disclosure under applicable Securities and Exchange Commission (“SEC”) rules will be disclosed at the same location as the Standards of Conduct on our website.

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INSURANCE

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

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

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

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

COMPANY INFORMATION

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

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

report we file with or furnish to the SEC.

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

FORWARD-LOOKING STATEMENTS

This report includes “forward-looking statements” within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Exchange Act, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. 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 following:

· The future impact of the Affordable Care Act on our business and the enactment of, or changes in, laws and regulations affecting the healthcare industry generally;

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- The effect that adverse economic conditions have on our volumes and our ability to collect outstanding receivables on a timely basis, among other things;

- Adverse litigation or regulatory developments;

- Our ability to enter into managed care provider arrangements on acceptable terms;

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

- Competition;

- Our success in implementing our business development plans, including growing our outpatient business;

- Our ability to hire and retain qualified personnel, especially healthcare professionals;

- The availability and terms of capital to fund the expansion of our business, including the acquisition of additional facilities;

- Our success in marketing Conifer's revenue cycle management, healthcare information management, management services, and patient communications and engagement services;

- Our ability to fully realize the anticipated benefits and synergies of our acquisitions and to successfully complete the integration of businesses we acquire, including Vanguard in particular;

- Our ability to identify and execute on measures designed to save or control costs or streamline operations;

- The impact of our significant indebtedness;

- Our success in operating our health plans and accountable care networks; and

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

Also included among the foregoing factors are the positive and negative effects of health reform legislation on reimbursement and utilization, as well as the future design of provider networks and insurance plans, including pricing, provider participation, coverage, and co-pays and deductibles.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in this report. Should one or more of the risks and uncertainties described in this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking 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.

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties — many of which are beyond our control — that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in this report were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and

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our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment.

We cannot predict with certainty the ultimate net effect that the Affordable Care Act may have on our business, financial condition, results of operations or cash flows.

The Affordable Care Act is changing how healthcare services in the United States are covered, delivered and reimbursed. The expansion of health insurance coverage under the law has resulted in a material increase in the number of patients using our facilities who have either private or public program coverage and a material decrease in uninsured and charity care admissions. However, it remains difficult to predict the full impact of the ACA on our future revenues and operations at this time due to uncertainty regarding a number of material factors, including:

- how many states will ultimately implement the Medicaid expansion provisions and under what terms (a number of states in which we operate, including Florida and Texas, have chosen not to expand their Medicaid programs at this time);
- how many currently uninsured individuals will ultimately obtain coverage (either private health insurance or Medicaid) as a result of the Affordable Care Act;
- what percentage of our newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the extent to which states will enroll new Medicaid participants in managed care programs;
- the pace at which insurance coverage expands, including the pace of different types of coverage expansion;
- future changes in the rates paid to hospitals by private payers for newly covered individuals, including those covered through health insurance exchanges and those who might be covered under the Medicaid program under contracts with a state;
- future changes in the rates paid by state governments under the Medicaid program for newly covered individuals;
- the percentage of individuals in the exchanges who select the high-deductible plans, considering that health insurers offering those kinds of products have traditionally sought to pay lower rates to hospitals; and

- the extent to which the provisions of the Affordable Care Act will put pressure on the profitability of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

In addition, the Affordable Care Act continues to be subject to possible delays, revisions and even elimination as a result of court challenges and actions by Congress. Any ruling or other action that negatively impacts the number of individuals who have health insurance coverage could have a material adverse effect on our results of operations and cash flows.

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Furthermore, the Affordable Care Act provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid DSH payments, and the establishment of programs where reimbursement is tied to quality and integration. A substantial portion of both our patient volumes and, as result, our revenues is derived from government healthcare programs, principally Medicare and Medicaid. Any reductions to our reimbursement under the Medicare and Medicaid programs pursuant to the ACA could adversely affect our business and results of operations to the extent such reductions are not offset by increased revenues from providing care to previously uninsured individuals. It is difficult to predict the future effect on our revenues resulting from reductions to Medicare and Medicaid spending because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from the Medicare and Medicaid programs when the reductions are fully implemented;

- whether future reductions required by the Affordable Care Act will be changed by statute prior to becoming effective;

- the size of the annual productivity adjustment to the market basket;

- the reductions to Medicaid DSH payments commencing in FFY 2017;

- what the losses in revenues, if any, will be from the ACA's quality initiatives;

- how successful accountable care networks in which we participate will be at coordinating care and reducing costs or whether they will decrease reimbursement;

- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and

- reductions to Medicare payments CMS may impose for "excessive readmissions."

In addition, we may continue to experience a high level of bad debt expense and have to provide uninsured discounts and charity care for persons living in the country illegally who are not permitted to enroll in a health insurance exchange or government healthcare program.

In general, there is still significant uncertainty with respect to the positive and negative effects the Affordable Care Act may have on reimbursement, utilization and the future design of provider networks and insurance plans (including pricing, provider participation, coverage, co-pays and deductibles), and the multiple models that attempt to forecast those effects may differ materially from our expectations. 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 individuals who will obtain and retain 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.

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

We currently have thousands of managed care contracts with various HMOs and PPOs. The amount of our managed care net patient revenues during the year ended December 31, 2014 was $9.3 billion, which represented approximately 59% of our total net patient revenues before provision for doubtful accounts. Approximately 62% of our managed care net patient revenues for the year ended December 31, 2014 was derived from our top ten managed care payers. In the year ended December 31, 2014, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 71% higher than our aggregate yield on a per admission basis from

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governmental payers, including managed Medicare and Medicaid insurance plans. In addition, at December 31, 2014, approximately 60% of our net accounts receivable related to continuing operations were due from managed care payers.

Our ability to negotiate favorable contracts with HMOs, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization reviews and greater enrollment in managed care programs, such as HMOs and PPOs. The trend toward consolidation among private managed care payers tends to increase their bargaining power over prices and fee structures. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services, coupled with any difficulties in collecting receivables from managed care payers, could have a material adverse effect on our financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from private payers could be exacerbated if we are not able to manage our operating costs effectively.

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

For the year ended December 31, 2014, approximately 22% of our net patient revenues before provision for doubtful accounts for our general hospitals were related to the Medicare program, and approximately 9% of our net patient revenues before provision for doubtful accounts for our general hospitals were related to various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. In addition to the changes affected by the Affordable Care Act, the Medicare and Medicaid programs are subject to: other statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. Any material adverse effects resulting from future reductions in payments from government programs could be exacerbated if we are not able to manage our operating costs effectively.

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 or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to

providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted 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.

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

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The industry trend toward value-based purchasing may negatively impact our revenues.

We believe that value-based purchasing initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities and may negatively impact our revenues if we are unable to meet expected quality standards. The Affordable Care Act contains a number of provisions intended to promote value-based purchasing in federal healthcare programs. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition, hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions, also known as HACs, unless the conditions were present at admission. Beginning in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year will receive reduced Medicare reimbursements. The ACA also prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider-preventable conditions.

There is a trend among private payers toward value-based purchasing of healthcare services, as well. Many large commercial payers require hospitals to report quality data, and several of these payers will not reimburse hospitals for certain preventable adverse events. We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenues if we are unable to meet quality standards established by both governmental and private payers.

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

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

In the future, we expect to encounter increased competition from system-affiliated hospitals and healthcare companies in specific geographic markets. We also face competition from specialty hospitals (some of which are physician-owned) and unaffiliated freestanding outpatient centers for market share in high margin services and for quality physicians and personnel. Furthermore, some of the hospitals that compete with our hospitals are owned by government agencies or not-for-profit organizations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. As is the case with our hospitals, some of our health plan competitors are owned by governmental agencies or non-profit corporations that have greater financial resources than we do. If our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than we are, we may experience an overall decline in patient volumes.

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

We are subject to medical malpractice lawsuits, class action lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large demands, as well as substantial defense costs. Even in states that have imposed caps on damages, litigants are seeking recoveries under new theories of liability that might not be

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subject to such caps. Our professional and general liability insurance does not cover all claims against us, and it may not continue to be available at a reasonable cost for us to maintain at adequate levels, as the healthcare industry has seen significant increases in the cost of such insurance due to increased litigation. We cannot predict the outcome of current or future legal actions against us or the effect that judgments or settlements in such matters may have on us or on our insurance costs. Additionally, all professional and general liability insurance we purchase is subject to policy limitations. If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period. Any losses not covered by or in excess of the amounts maintained under insurance policies will be funded from our working capital. Furthermore, one or more of our insurance carriers could become insolvent and unable to fulfill its or their obligations to defend, pay or reimburse us when those obligations become due. In that case or if payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition, results of operations or cash flows.

If we are unable to recruit and retain an appropriate number of quality physicians on the medical staffs of our hospitals, our business may suffer.

The success of our business depends in significant part on the number, quality and specialties of the physicians on the medical staffs of our hospitals, the admitting practices of those physicians and maintaining good relations with those physicians. Although we operate physician practices and, where permitted by law, employ physicians, physicians are often not employees of the hospitals at which they practice and, in many of the markets we serve, most physicians have admitting privileges at other hospitals in addition to our hospitals. Such physicians may terminate their association with our hospitals or admit their patients to competing hospitals at any time. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment and hospital facilities that meet the needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

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

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

operating revenues. In general, our failure to recruit and retain qualified management, experienced nurses and other medical support personnel, or to control labor costs, could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Increased labor union activity is another factor that could adversely affect our labor costs. As of December 31, 2014, approximately 20% of our employees were represented by labor unions. These employees — primarily registered nurses and service and maintenance workers — are located at 38 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six 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

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net operating revenues. Future organizing activities by labor unions could increase our level of union representation; to the extent a greater portion of our employee base unionizes, it is possible our labor costs could increase materially.

Conifer's future success also depends in part on our ability to attract, hire, integrate and retain key personnel. Competition for the caliber and number of employees we require at Conifer is intense. We may face difficulty identifying and hiring qualified personnel at compensation levels consistent with our existing compensation and salary structure. In addition, we invest significant time and expense in training Conifer's employees, which increases their value to competitors who may seek to recruit them. If we fail to retain our Conifer employees, we could incur significant expenses in hiring, integrating and training their replacements, and the quality of Conifer's services and its ability to serve its customers could diminish, resulting in a material adverse effect on that segment of our business.

Our business and financial results could be harmed by violations of existing regulations or compliance with new or changed regulations.

Our hospitals, outpatient centers and related healthcare businesses are subject to extensive federal, state and local regulation relating to, among other things, licensure, conduct of operations, privacy of patient information, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the healthcare industry are extremely complex and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. If a determination is made that we were in violation of such laws, rules or regulations, we could be subject to penalties or liabilities or required to make significant changes to our operations. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on the value of our common stock and our business reputation could suffer. Furthermore, healthcare, as one of the largest industries in the United States, continues to attract much legislative interest and public attention. We are unable to predict the future course of federal, state and local healthcare regulation or legislation, including Medicare and Medicaid statutes and regulations. Further changes in the regulatory framework negatively affecting healthcare providers could have a material adverse effect on our business, financial condition, results of operations or cash flows.

We are also required to comply with various federal and state labor laws, rules and regulations governing a variety of workplace wage and hour issues. From time to time, we have been and expect to continue to be subject to regulatory proceedings and private litigation concerning our application of such laws, rules and regulations.

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.

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

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. However, the market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market (including software vendors and other technology-supported revenue cycle management outsourcing companies, traditional consultants and information technology outsourcing firms), as well as from the staffs of hospitals and other healthcare providers who handle these processes internally. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Moreover, existing or new competitors may introduce

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technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition may result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

The failure to comply with consumer financial, debt collection and credit reporting laws and regulations could subject Conifer and its subsidiaries to fines and other liabilities, as well as harm Conifer's business and reputation.

Conifer and its subsidiaries are subject to numerous consumer financial, debt collection and credit reporting laws, rules and regulations. Moreover, regulations governing debt collection are subject to changing interpretations that may be inconsistent among different jurisdictions. Conifer's failure to comply with such requirements could result in, among other things, the issuance of cease and desist orders (which can include orders for restitution or rescission of contracts, as well as other kinds of affirmative relief), the imposition of fines or refunds, and other civil and criminal penalties, some of which could be significant in the case of knowing or reckless violations. In addition, Conifer's failure to comply with the laws and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its customers, or give customers the right to terminate Conifer's services agreements with them, among other things, any of which could have an adverse effect on Conifer's business. Furthermore, if Conifer or its subsidiaries become subject to fines or other penalties, it could harm Conifer's reputation, thereby making it more difficult for Conifer to retain existing customers or attract new customers.

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

As a provider of healthcare services, information technology is a critical component of the day-to-day operation of our business. We rely on our information technology to process, transmit and store sensitive or confidential data, including electronic health records, other protected health information, and financial, payment and other personal data of patients, as well as to store our proprietary and confidential business performance data. We utilize a diversified data and voice network, along with technology systems for billing, supply chain, clinical information systems and labor management. Our systems, in turn, interface with and rely upon third-party systems. Although we have redundancies and other measures designed to protect the security and availability of the data we process, transmit and store, our information technology and infrastructure have been, and will likely continue to be, subject to computer viruses, attacks by hackers, or breaches due to employee error or malfeasance. While we are not aware of having experienced a material breach of cybersecurity, the preventive actions we take to reduce the risk of such incidents and protect our information technology may not be sufficient in the future. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we may be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, or invest in new technology designed to mitigate security risks. Third parties to whom we outsource certain of our functions, or with whom our systems interface, are also subject to the risks outlined above and may not have or use appropriate controls to protect confidential information. A breach or attack affecting one of our third-party service providers or partners could harm our business even if we do not control the service that is attacked. Further, successful cyber-attacks at other healthcare

services companies, whether or not we are impacted, could lead to a general loss of customer confidence in our industry that could negatively affect us, including harming the market perception of the effectiveness of our security measures or of the healthcare industry in general, which could result in reduced use of our services. Though we have insurance against some cyber-risks and attacks, it may not be sufficient to offset the impact of a material loss event. Furthermore, our networks and technology systems are subject to disruption due to events such as a major earthquake, fire, telecommunications failure, terrorist attack or other catastrophic event. Any such breach or system interruption could result in the unauthorized disclosure, misuse or loss of confidential, sensitive or proprietary information, could negatively impact our ability to conduct normal business operations (including the collection of revenues), and could result in potential liability, regulatory penalties, negative publicity and damage to our reputation, any of which could have a material adverse effect on our business, financial position, results of operations or cash flows.

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We cannot provide any assurances that acquisitions, joint ventures and strategic alliances will achieve their business goals or the cost and service synergies we expect.

We have completed a number of acquisitions, joint ventures and strategic alliances as part of our business strategy, and we expect to enter into similar transactions in the future. We cannot provide any assurances that these acquisitions, joint ventures or strategic alliances will achieve their business goals or the cost and service synergies we expect. Furthermore, the nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our results could be adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our results could be adversely affected. In addition, our relationships with not-for-profit healthcare systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current revenue rulings published by the IRS, as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit healthcare systems and related joint venture arrangements.

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

We believe broad economic factors — including higher levels of unemployment and instability in consumer spending — have affected our volumes and our ability to collect outstanding receivables. The United States economy remains unpredictable. If industry trends (including reductions in commercial managed care enrollment and patient decisions to postpone or cancel elective and non-emergency healthcare procedures) or general economic conditions worsen, we may not be able to sustain future profitability, and our liquidity and ability to repay our outstanding debt may be harmed.

Furthermore, the availability of liquidity and credit to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, to access those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions, and our ability to refinance existing debt. An economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under our credit facilities, causing them to fail to meet their obligations to us.

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

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

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The amount and terms of our current and any future debt could, among other things, adversely affect our ability to raise additional capital to fund our operations and limit our ability to react to changes in the economy or our industry.

As of December 31, 2014, we had approximately $11.7 billion of total long-term debt, as well as approximately $119 million in standby letters of credit outstanding in the aggregate, under our senior secured revolving credit facility ("Credit Agreement") and our letter of credit facility agreement ("LC Facility"). Our Credit Agreement is collateralized by patient accounts receivable of all of our wholly owned acute care and specialty hospitals, and our LC Facility is guaranteed and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. From time to time, we expect to engage in additional capital market, bank credit and other financing activities depending on our needs and financing alternatives available at that time.

Our substantial indebtedness could have important consequences, including the following:

- Our Credit Agreement, LC Facility and indentures contain, and any future debt obligations may contain, covenants that, among other things, restrict our ability to pay dividends, incur additional debt and sell assets. Our Credit Agreement and LC Facility also require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. The indentures contain covenants that, among other things, restrict our ability and the ability of our subsidiaries to incur liens, consummate asset sales, enter into sale and lease-back transactions, or consolidate, merge or sell all or substantially all assets. If we do not comply with these obligations, it may cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

- We may be more vulnerable in the event of a deterioration in our business, in the healthcare industry or in the economy generally, or if federal or state governments substantially limit or reduce reimbursement under the Medicare or Medicaid programs.

- We are required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which reduces the amount of funds available for our operations, capital expenditures and acquisitions.

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

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our Credit Agreement, LC Facility and the indentures governing our outstanding senior notes and senior secured notes. If new indebtedness is added to our current debt levels, the related risks that we now face could intensify.

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

At December 31, 2014, we had federal net operating loss ("NOL") carryforwards of approximately $1.6 billion pretax available to offset future taxable income. These NOL carryforwards will expire in the years 2024 to 2033. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an annual limitation and will depend on the amount

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of taxable income we generate in future periods. There is no assurance that we will be able to fully utilize the NOL carryforwards. Furthermore, we could be required to record a valuation allowance related to the amount of the NOL carryforwards that may not be realized, which could adversely impact our results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

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

ITEM 3. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 15 to our Consolidated Financial Statements, which is incorporated by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II.

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

Common Stock. Our common stock is listed on the New York Stock Exchange ("NYSE") under the symbol "THC." The following table sets forth, for the periods indicated, the high and low sales prices per share of our common stock on the NYSE:

	High	Low
Year Ended December 31, 2014		
First Quarter	$ 48.70	$ 38.40
Second Quarter	50.25	37.95
Third Quarter	63.61	44.20
Fourth Quarter	59.65	46.01
Year Ended December 31, 2013		
First Quarter	$ 48.25	$ 33.00
Second Quarter	49.47	38.17
Third Quarter	47.08	36.87
Fourth Quarter	48.48	38.71

On February 13, 2015, the last reported sales price of our common stock on the NYSE composite tape was $44.30 per share. As of that date, there were 4,405 holders of record of our common stock. Our transfer agent and registrar is Computershare. Shareholders with questions regarding their stock certificates, including inquiries related to exchanging or replacing certificates or changing an address, should contact the transfer agent at (866) 229-8416.

Cash Dividends on Common Stock. We have not paid cash dividends on our common stock since the first quarter of fiscal 1994. We currently intend to retain future earnings, if any, for the operation and development of our business and, accordingly, do not currently intend to pay any cash dividends on our common stock. Our board of directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to pay any cash dividends in the future. Our senior secured revolving credit agreement and our letter of credit facility agreement contain provisions that limit the payment of cash dividends on our common stock if we do not meet certain financial ratios.

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

Stock Performance Graph. The following graph shows the cumulative, five-year total return for our common stock compared to three indices, each of which includes us. The Standard & Poor's 500 Stock Index includes 500 companies representing all major industries. The Standard & Poor's Health Care Composite Index is a group of 55 companies involved in a variety of healthcare-related businesses. Because the Standard & Poor's Health Care Composite Index is heavily weighted by pharmaceutical and medical device companies, we believe that at times it may be less useful than the Hospital Management Peer Group Index included below. We compiled this Peer Group Index by selecting publicly traded companies that have as their primary business the management of acute care hospitals and that have been in business for all five of the years shown. These companies are: Community Health Systems, Inc. (CYH), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS).

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Performance data assumes that $100.00 was invested on December 31, 2009 in our common stock and each of the indices. The data assumes the reinvestment of all cash dividends and the cash value of other distributions. Stock price performance shown in the graph is not necessarily indicative of future stock price performance.

COMPARISON OF FIVE YEAR CUMULATIVE TOTAL RETURN

	12/09	12/10	12/11	12/12	12/13	12/14
Tenet Healthcare Corporation	$ 100.00	$ 124.12	$ 95.18	$ 150.60	$ 195.36	$ 235.02
S&P 500	$ 100.00	$ 115.06	$ 117.49	$ 136.30	$ 180.44	$ 205.14
S&P Health Care	$ 100.00	$ 102.90	$ 116.00	$ 136.75	$ 193.45	$ 242.46
Peer Group	$ 100.00	$ 122.91	$ 88.22	$ 129.87	$ 189.43	$ 251.65

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ITEM 6. SELECTED FINANCIAL DATA

OPERATING RESULTS

The following tables present selected consolidated financial data for Tenet Healthcare Corporation and its wholly owned and majority-owned subsidiaries for the years ended December 31, 2010 through 2014. Because we acquired Vanguard Health Systems, Inc. ("Vanguard") on October 1, 2013, the 2013 columns in the tables below include results of operations for Vanguard and its consolidated subsidiaries for the three months ended December 31, 2013 only. All amounts related to shares, share prices and earnings per share for periods ending prior to October 11, 2012 have been restated to give retrospective presentation for the reverse stock split described in Note 2 to our Consolidated Financial Statements. The tables should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and notes thereto included in this report.

	Years Ended December 31,				
	2014	2013	2012	2011	2010
	(In Millions, Except Per-Share Amounts)				
Net operating revenues:					
Net operating revenues before provision for doubtful accounts	$ 17,920	$ 12,074	$ 9,904	$ 9,371	$ 8,992
Less: Provision for doubtful accounts	1,305	972	785	717	727
Net operating revenues	16,615	11,102	9,119	8,654	8,265
Operating expenses:					
Salaries, wages and benefits	8,023	5,371	4,257	4,015	3,830
Supplies	2,630	1,784	1,552	1,548	1,542
Other operating expenses, net	4,114	2,701	2,147	2,020	1,857
Electronic health record incentives	(104)	(96)	(40)	(55)	—
Depreciation and amortization	849	545	430	398	380
Impairment and restructuring charges, and acquisition-related costs	153	103	19	20	10
Litigation and investigation costs, net of insurance recoveries	25	31	5	55	12
Operating income	925	663	749	653	634
Interest expense	(754)	(474)	(412)	(375)	(424)
Loss from early extinguishment of debt	(24)	(348)	(4)	(117)	(57)
Investment earnings	—	1	1	3	5
Income (loss) from continuing operations, before income taxes	147	(158)	334	164	158
Income tax benefit (expense)	(49)	65	(125)	(61)	977
	$ 98	$ (93)	$ 209	$ 103	$ 1,135

Income (loss) from continuing operations, before discontinued operations and cumulative effect of change in accounting principle					
Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	$ 0.35	$ (1.21)	$ 1.77	$ 0.58	$ 9.09
Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations	$ 0.34	$ (1.21)	$ 1.70	$ 0.56	$ 8.03

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The operating results data presented above is not necessarily indicative of our future results of operations. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services ("CMS") of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated 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 restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, 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.

BALANCE SHEET DATA

	December 31,				
	2014	2013	2012	2011	2010
	(In Millions)				
Working capital (current assets minus current liabilities)	$ 1,140	$ 599	$ 918	$ 542	$ 586
Total assets	18,141	16,450	9,044	8,462	8,500
Long-term debt, net of current portion	11,695	10,696	5,158	4,294	3,997
Total equity	785	878	1,218	1,492	1,819

CASH FLOW DATA

	Years Ended December 31,				
	2014	2013	2012	2011	2010
	(In Millions)				
Net cash provided by operating activities	$ 687	$ 589	$ 593	$ 497	$ 472
Net cash used in investing activities	(1,322)	(2,164)	(662)	(503)	(420)
Net cash provided by (used in) financing activities	715	1,324	320	(286)	(337)

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is Hospital Operations and other, which is focused on 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 Consolidated Financial Statements, includes the following sections:

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

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day and per visit amounts). Continuing operations information includes the results of (i) our same 49 hospitals operated throughout the years ended December 31, 2014, 2013 and 2012, (ii) Vanguard and its consolidated subsidiaries, which we acquired effective October 1, 2013, but only for the period from the date of acquisition through December 31, 2014, (iii) Texas Regional Medical Center at Sunnyvale ("TRMC"), in which we acquired a majority interest on June 3, 2014, but only for the period from the date of acquisition through December 31, 2014, (iv) Resolute Health Hospital, which we opened on June 24, 2014, and (v) Emanuel Medical Center, which we acquired on August 1, 2014, but only for the period from the date of acquisition through December 31, 2014. Continuing operations information excludes the results of our hospitals and other businesses that have previously been classified as discontinued operations for accounting purposes. Certain prior-year amounts have been reclassified to conform to the current-year presentation.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Extension and Expansion of Conifer Agreement—In January 2015, Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives (“CHI”) to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. As further described in Note 22 to our Consolidated Financial Statements, at that time and as a result of CHI’s relationship with Tenet, CHI received an increase in its minority ownership position in Conifer.

Valley Baptist Joint Venture Put Option—As part of the acquisition of Vanguard, we obtained a 51% controlling interest in a limited liability company that held the assets and liabilities of Valley Baptist Health System (“Valley Baptist”), which consists of our hospitals in Brownsville and Harlingen, Texas. The remaining 49% non-controlling interest in the joint venture was held by the former owner of Valley Baptist (the “seller”). The joint venture operating agreement included a put option that would allow the seller to require us to purchase all or a portion of the seller’s remaining non-controlling interest in the limited liability company at certain specified time periods. In November 2014, the seller provided notice of its intent to exercise the put option for its entire 49% non-controlling interest. In connection with the settlement of the put option, we acquired the remaining 49% non-controlling interest from the seller on February 11, 2015 in exchange for approximately $254 million in cash. The redemption value of the put option was calculated pursuant to the terms of the operating agreement based on the operating results and the debt of the joint venture. As a result, we now own 100% of Valley Baptist as of February 11, 2015.

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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.

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, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We 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 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. 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 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, acquisitions and strategic partnerships, and to expand our Conifer services business.

From time to time, we build new facilities, make acquisitions of healthcare assets and companies, and enter into joint venture arrangements or affiliations with healthcare businesses in markets where we believe our operating strategies can improve performance and create shareholder value. In 2014, 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. In the year ended December 31, 2014, we also opened 27 new outpatient facilities and acquired nine other outpatient businesses.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the year ended December 31, 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 other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

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We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. Conifer provides services to approximately 800 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 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, government agencies and other entities. In January 2015, Conifer announced a 10-year extension and expansion of its agreement with CHI to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. 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"). During the year ended December 31, 2014, we recognized approximately $104 million of Medicare and Medicaid electronic health record ("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 year ended December 31, 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. 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 launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans. As of December 31, 2014, we operated hospitals in five of the states (Arizona, California, Illinois, Massachusetts and Michigan) that expanded their Medicaid programs in 2014 and one of the states (Pennsylvania) that is expanding in 2015.

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 successfully integrating Vanguard's business and operations into

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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 this report.

RESULTS OF OPERATIONS—OVERVIEW

We believe our results of operations for our most recent fiscal quarter best reflect recent trends we are experiencing with respect to volumes, revenues and expenses; therefore, we have provided below information about these metrics for the three months ended December 31, 2014 and 2013 on both a continuing operations and a same-hospital operations basis.

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, TRMC, 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 the case of TRMC and Emanuel Medical Center, only for the period of time from acquisition to December 31, 2014). We believe this information is useful to investors because it reflects our current portfolio of hospitals and the recent trends we are experiencing with respect to volumes, revenues and expenses.

	Total Hospital Continuing Operations Three Months Ended December 31,		
	2014	2013	Increase (Decrease)
Total admissions	202,337	190,506	6.2 %
Adjusted patient admissions(1)	347,790	325,410	6.9 %
Paying admissions (excludes charity and uninsured)	191,081	176,316	8.4 %
Charity and uninsured admissions	11,256	14,190	(20.7)%
Admissions through emergency department	127,361	116,592	9.2 %
Emergency department visits	737,680	663,114	11.2 %
Total emergency department admissions and visits	865,041	779,706	10.9 %
Surgeries — inpatient	55,474	53,119	4.4 %
Surgeries — outpatient	127,776	115,611	10.5 %
Total surgeries	183,250	168,730	8.6 %
Patient days — total	937,803	880,737	6.5 %
Adjusted patient days(1)	1,592,166	1,481,291	7.5 %
Average length of stay (days)	4.63	4.62	0.2 %
Average licensed beds	20,805	20,294	2.5 %
Utilization of licensed beds(2)	49.0 %	47.2 %	1.8 %(3)

Total visits	2,145,138	1,916,932	11.9 %
Paying visits (excludes charity and uninsured)	1,976,854	1,733,345	14.0 %
Charity and uninsured visits	168,284	183,587	(8.3) %
Net inpatient revenues	$ 2,719	$ 2,372	14.6 %
Net outpatient revenues	$ 1,539	$ 1,357	13.4 %
Net inpatient revenue per admission	$ 13,438	$ 12,451	7.9 %
Net inpatient revenue per patient day	$ 2,899	$ 2,693	7.6 %
Net outpatient revenue per visit	$ 717	$ 708	1.3 %
Net patient revenue per adjusted patient admission(1)	$ 12,243	$ 11,459	6.8 %
Net patient revenue per adjusted patient day(1)	$ 2,674	$ 2,517	6.2 %

(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) 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 December 31, 2014 compared to the three months ended December 31, 2013.

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Operating Statistics on a Same-Hospital Basis—The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of hospitals we had been operating for at least one year as of the beginning of the fourth quarter on October 1, 2014. The 28 hospitals we acquired from Vanguard on October 1, 2013 are included in same-hospital continuing operations for the three months ended December 31, 2014 and 2013, while the results of TRMC, 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, are excluded.

	Same-Hospital Continuing Operations Three Months Ended December 31,					
Admissions, Patient Days and Surgeries	2014		2013		Increase (Decrease)	
Total admissions	198,219		190,506		4.0	%
Adjusted patient admissions(1)	340,125		325,410		4.5	%
Paying admissions (excludes charity and uninsured)	187,115		176,316		6.1	%
Charity and uninsured admissions	11,104		14,190		(21.7)	%
Admissions through emergency department	124,600		116,592		6.9	%
Paying admissions as a percentage of total admissions	94.4	%	92.6	%	1.8	%(2)
Charity and uninsured admissions as a percentage of total admissions	5.6	%	7.4	%	(1.8)	%(2)
Emergency department admissions as a percentage of total admissions	62.9	%	61.2	%	1.7	%(2)
Surgeries — inpatient	54,518		53,119		2.6	%
Surgeries — outpatient	126,818		115,611		9.7	%
Total surgeries	181,336		168,730		7.5	%
Patient days — total	921,926		880,737		4.7	%
Adjusted patient days(1)	1,562,581		1,481,291		5.5	%
Average length of stay (days)	4.65		4.62		0.6	%
Number of hospitals (at end of period)	77		77		—	
Licensed beds (at end of period)	20,407		20,293		0.6	%
Average licensed beds	20,398		20,294		0.5	%
Utilization of licensed beds(3)	49.1	%	47.2	%	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 December 31, 2014 compared to the three months ended December 31, 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 7,713, or 4.0%, in the three months ended December 31, 2014 months compared to the three months ended December 31, 2013. Total same-hospital surgeries increased by 7.5% in the three months ended December 31, 2014 compared to the same period in 2013, comprised of a 9.7% increase in outpatient surgeries primarily due to our outpatient development strategies and a 2.6% increase in inpatient surgeries. Our same-hospital emergency department admissions increased 6.9% in the three months ended December 31, 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 21.7% in the three months ended December 31, 2014 compared to the three months ended December 31, 2013 on a

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same-hospital basis, primarily due to Medicaid expansion in five of the states in which we operate and health insurance exchange coverage under the ACA.

	Same-Hospital Continuing Operations Three Months Ended December 31,					
Outpatient Visits	2014		2013		Increase (Decrease)	
Total visits	2,100,683		1,916,931		9.6	%
Paying visits (excludes charity and uninsured)	1,935,937		1,733,344		11.7	%
Charity and uninsured visits	164,746		183,587		(10.3)	%
Emergency department visits	711,351		663,114		7.3	%
Surgery visits	126,818		115,611		9.7	%
Paying visits as a percentage of total visits	92.2	%	90.4	%	1.8	%(1)
Charity and uninsured visits as a percentage of total visits	7.8	%	9.6	%	(1.8)	%(1)

(1) The change is the difference between the amounts shown for the three months ended December 31, 2014 compared to the three months ended December 31, 2013.

Total same-hospital outpatient visits increased 183,752, or 9.6%, in the three months ended December 31, 2014 compared to the three months ended December 31, 2013, which included 11.7% growth for paying visits. Approximately 86% of the growth in outpatient visits was organic.

Same-hospital outpatient surgery visits increased by 9.6% in the three months ended December 31, 2014 compared to the same period in 2013. Charity and uninsured outpatient visits decreased by 10.3% in the three months ended December 31, 2014 compared to the three months ended December 31, 2013 on a same-hospital basis, primarily due to Medicaid expansion in five of the states in which we operate and health insurance exchange coverage under the ACA.

Same-Hospital
Continuing Operations
Three Months Ended December 31,

Revenues	2014	2013	Increase (Decrease)
Net operating revenues	$ 4,386	$ 3,885	12.9 %
Revenues from charity and the uninsured	$ 261	$ 288	(9.4) %
Net inpatient revenues(1)	$ 2,669	$ 2,372	12.5 %
Net outpatient revenues(1)	$ 1,495	$ 1,357	10.2 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $100 million and $121 million for the three months ended December 31, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $161 million and $167 million for the three months ended December 31, 2014 and 2013, respectively.

Net operating revenues increased by $501 million, or 12.9%, on a same-hospital basis in the three months ended December 31, 2014 compared to the same period in 2013, primarily due to increases in inpatient and outpatient volumes, improved managed care pricing, increased net revenues related to the California provider fee program, and increased revenues from services provided by our Conifer subsidiary to third parties. Net operating revenues in the three months ended December 31, 2014 included $150 million of net revenues from the California provider fee program compared to $19 million during the three months ended December 31, 2013 due to the timing of the approval of the 2014 program. Also, net patient revenues increased by 11.7% in the three months ended December 31, 2014 compared to the same period in 2013. Revenues from charity and the uninsured decreased 9.4% in the three months ended

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December 31, 2014 compared to the three months ended December 31, 2013 primarily due to Medicaid expansion in five of the states in which we operate and health insurance exchange coverage under the ACA.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 13,465	$ 12,451	8.1 %
Net inpatient revenue per patient day	$ 2,895	$ 2,693	7.5 %
Net outpatient revenue per visit	$ 712	$ 708	0.6 %
Net patient revenue per adjusted patient admission(1)	$ 12,243	$ 11,459	6.8 %
Net patient revenue per adjusted patient day(1)	$ 2,665	$ 2,517	5.9 %

(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 8.1% and 0.6%, respectively, on a same-hospital basis in the three months ended December 31, 2014 compared to the same period in 2013. Net inpatient revenue per admission reflects the favorable impact of $150 million of net revenues from the California provider fee program in the three months ended December 31, 2014 compared to $19 million for the same period in 2013 due to the timing of the approval of the 2014 program. Improved terms of our managed care contracts also favorably impacted both net inpatient revenue per admission and net outpatient revenue per visit.

	Same-Hospital Continuing Operations Three Months Ended December 31,		
Provision for Doubtful Accounts	2014	2013	Increase (Decrease)
Provision for doubtful accounts	$ 344	$ 348	(1.1)%
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.3 %	8.2 %	(0.9)%(1)

(1) The change is the difference between the amounts shown for the three months ended December 31, 2014 compared to the three months ended December 31, 2013.

Provision for doubtful accounts decreased by $4 million, or 1.1%, in the three months ended December 31, 2014

compared to the same period in 2013 on a same-hospital basis. The decrease in the provision for doubtful accounts related to a decline in uninsured revenues primarily due to the expansion of insurance coverage under the ACA, substantially offset by the impact of a $501 million increase in net operating revenues and the 120 basis point decrease in our self-pay collection rate for our 49 hospitals operated throughout the years ended December 31, 2014 and 2013, as well as a greater amount of 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

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December 31, 2014 and 28.7% at December 31, 2013 for our 49 hospitals operated throughout the years ended December 31, 2014 and 2013.

	Same-Hospital Continuing Operations Three Months Ended December 31,			
Selected Operating Expenses	2014	2013	Increase (Decrease)	
Hospital Operations and other				
Salaries, wages and benefits	$ 1,888	$ 1,703	10.9	%
Supplies	675	626	7.8	%
Other operating expenses	960	932	3.0	%
Total	$ 3,523	$ 3,261	8.0	%
Conifer				
Salaries, wages and benefits	$ 196	$ 169	16.0	%
Other operating expenses	67	59	13.6	%
Total	$ 263	$ 228	15.4	%
Total				
Salaries, wages and benefits	$ 2,084	$ 1,872	11.3	%
Supplies	675	626	7.8	%
Other operating expenses	1,027	991	3.6	%
Total	$ 3,786	$ 3,489	8.5	%
Rent/lease expense(1)				
Hospital Operations and other	$ 57	$ 54	5.6	%
Conifer	3	4	(25.0)	%
Total	$ 60	$ 58	3.4	%
Hospital Operations and other(2)				
Salaries, wages and benefits per adjusted patient day	$ 1,206	$ 1,144	5.4	%
Supplies per adjusted patient day	432	423	2.1	%
Other operating expenses per adjusted patient day	533	545	(2.2)	%
Total per adjusted patient day	$ 2,171	$ 2,112	2.8	%
Salaries, wages and benefits per adjusted patient admission	$ 5,539	$ 5,206	6.4	%
Supplies per adjusted patient admission	1,985	1,924	3.2	%
Other operating expenses per adjusted patient admission	2,449	2,482	(1.3)	%
Total per adjusted patient admission	$ 9,973	$ 9,612	3.8	%

(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 our health plans and our provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals.

Total selected operating expenses, which is defined as salaries, wages and benefits, supplies and other operating expenses, increased by 2.8% and 3.8% on a per adjusted patient day and per adjusted patient admission same-hospital basis, respectively, in the three months ended December 31, 2014 compared to the three months ended December 31, 2013.

Salaries, wages and benefits per adjusted patient admission increased by approximately 6.4% in the three months ended December 31, 2014 compared to the same period in 2013 on a same-hospital basis. This change is primarily due to a greater number of employed physicians, annual merit increases for certain of our employees, increased overtime and contract labor costs, 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 December 31, 2014 compared to the three months ended December 31, 2013.

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Supplies expense per adjusted patient admission on a same-hospital basis increased by 3.2% in the three months ended December 31, 2014 compared to the three months ended December 31, 2013. The change in supplies expense was primarily attributable to higher costs for pharmaceuticals, as well as volume growth in our supply-intensive surgical services.

Other operating expenses per adjusted patient admission decreased by 1.3% in the three months ended December 31, 2014 compared to the same period in 2013 on a same-hospital basis. This change is due to our higher patient volumes in the 2014 period, which has a favorable impact on this cost metric due to the fixed nature of certain costs in other operating expenses, decreased costs associated with funding indigent care services by certain of our hospitals, which costs were substantially offset by reduced net patient revenues, and gains of $24 million from the sales of certain assets, partially offset by higher medical fees primarily related to a greater number of employed and contracted physicians and increased malpractice expense. Malpractice expense in the 2014 period included an unfavorable adjustment of approximately $4 million due to a 25 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 a 43 basis point increase in the interest rate in the 2013 period.

Salaries, wages and benefits expense for Conifer increased by $27 million in the three months ended December 31, 2014 compared to the three months ended December 31, 2013 months 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, Conifer's acquisition of SPi Healthcare and growth in Conifer's services to CHI.

Other operating expenses for Conifer increased by $8 million in the three months ended December 31, 2014 compared to the three months ended December 31, 2013 due to higher costs related to growth in Conifer's business primarily attributable to the integration of the Vanguard facilities' revenue cycle operations now managed by Conifer, Conifer's acquisition of SPi Healthcare and growth in Conifer's services to CHI.

The table below shows the pre-tax and after-tax impact on continuing operations for the three months and years ended December 31, 2014 and 2013 of the following items:

	Three Months Ended December 31,		Year Ended December 31,	
	2014	2013	2014	2013
	(Expense) Income			
Impairment and restructuring charges, and acquisition-related costs	$ (63)	$ (58)	$ (153)	$ (103)
Litigation and investigation costs	(6)	(28)	(25)	(31)

Loss from early extinguishment of debt	—	—	(24)	(348)
Pre-tax impact	$ (69)	$ (86)	$ (202)	$ (482)
Total after-tax impact	$ (43)	$ (60)	$ (111)	$ (315)
Diluted per-share impact of above items	$ (0.42)	$ (0.60)	$ (1.11)	$ (3.06)
Diluted earnings per share, including above items	$ 0.61	$ (0.17)	$ 0.34	$ (1.21)

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $193 million at December 31, 2014 compared to $200 million at September 30, 2014.

Significant cash flow items in the three months ended December 31, 2014 included:

· Capital expenditures of $199 million;

· Purchases of businesses for $243 million, primarily from the acquisition by Conifer of SPi Healthcare, a physician practice revenue cycle company;

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- Interest payments of $239 million;

- Payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements of $53 million; and

- $220 million of net proceeds from borrowings under our revolving credit facility.

Net cash provided by operating activities was $687 million in the year ended December 31, 2014 compared to $589 million in the year ended December 31, 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 $610 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, litigation and investigation costs, impairment and restructuring charges, acquisition-related costs, and depreciation and amortization in the year ended December 31, 2014 compared to the year ended December 31, 2013;

- $8 million more cash used in operating activities from discontinued operations;

- An increase of $54 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;

- Lower net cash receipts of approximately $114 million in 2014 from the California provider fee program due to the timing of approval of the program; and

- Additional interest payments of $300 million.

Cash flows during the three months ended December 31, 2014 were negatively impacted by a temporary buildup in accounts receivable of certain hospitals acquired from Vanguard due to the implementation of a new billing system that is expected to enhance efficiency.

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).

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:

	Year Ended December 31,		
Net Patient Revenues from:	2014	2013	2012
Medicare	21.9 %	21.8 %	23.4 %
Medicaid	9.4 %	9.0 %	8.4 %
Managed care	58.6 %	58.1 %	57.4 %
Indemnity, self-pay and other	10.1 %	11.1 %	10.8 %

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:

Year Ended December 31,

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Admissions from:	2014	2013	2012
Medicare	27.5 %	28.0 %	28.9 %
Medicaid	10.3 %	11.7 %	12.2 %
Managed care	54.5 %	50.0 %	48.8 %
Indemnity, self-pay and other	7.7 %	10.3 %	10.1 %

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services is the single largest payer of healthcare services in the United States. Nearly one third of all 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

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. 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 penalty percentage increases through 2016, and is adjusted for inflation beginning in 2017. 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. In 2014, two federal appeals court panels issued conflicting rulings on whether U.S. Internal Revenue Service regulations extending such subsidies to individuals who purchase coverage through the federal government's health insurance exchange (rather than a state-based exchange) are permissible. The U.S. Supreme Court will now consider the matter, and a ruling is expected in mid-2015. Any ruling or other action that negatively impacts the number of individuals who have health insurance coverage could have a material adverse effect on our results of operations and cash flows. Pending the Supreme Court's decision on this issue, the government has stated that it will continue paying the subsidies to insurance companies on behalf of consumers in the 34 states that use the federal exchange. As of December 31, 2014, we operated hospitals in two states that run their own health insurance exchanges and 12 states that rely on the federal exchange.

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. On February 10, 2014, the requirements of the employer mandate were delayed until January 1, 2016. Based on the Congressional Budget Office’s most recent estimates, we do not believe that the delay in enforcement of the employer mandate will have a discernible effect on insurance coverage.

Another 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 requires state legislative or regulatory action and the approval by CMS of a state Medicaid plan amendment. As of December 31, 2014, 27 states and the District of Columbia have taken action to expand Medicaid. We currently operate

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hospitals in five of the states (Arizona, California, Illinois, Massachusetts and Michigan) that expanded their Medicaid programs in 2014 and one of the states (Pennsylvania) 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. Even though the ACA expanded Medicaid eligibility, the law 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 individuals who will obtain and retain 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 this report.

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

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operations, for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2014, 2013 and 2012 are set forth in the following table:

	Year Ended December 31,		
Revenue Descriptions	2014(1)	2013	2012
Medicare severity-adjusted diagnosis-related group — operating	$ 1,677	$ 1,201	$ 1,109
Medicare severity-adjusted diagnosis-related group — capital	154	107	98
Outliers	69	53	51
Outpatient	953	632	522
Disproportionate share	370	250	217
Direct Graduate and Indirect Medical Education(2)	250	138	96
Other(3)	98	42	66
Adjustments for prior-year cost reports and related valuation allowances	30	32	109
Total Medicare net patient revenues	$ 3,601	$ 2,455	$ 2,268

(1) Includes revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013, as well as TRMC, Resolute Health Hospital and Emanuel Medical Center.
(2) Includes Indirect Medical Education revenue 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 below. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found under "Regulatory and Legislative Changes" below.

Acute Care Hospital Inpatient Prospective Payment System

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

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

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

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

Disproportionate Share Hospital Payments—In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately high share of low-income patients. Prior to October 1, 2013, DSH payments were determined annually based on certain statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. The ACA revised the Medicare DSH adjustment effective for discharges occurring on or after October 1, 2014. Under the revised methodology, hospitals will receive 25% of the amount they previously would have received under the pre-ACA formula. This amount is referred to as the "Empirically Justified Amount."

Hospitals qualifying for the Empirically Justified Amount of DSH payments are also eligible to receive an additional payment for uncompensated care (the "UC DSH Amount"). The UC DSH Amount is a hospital's share of a pool of funds that equal 75% of what otherwise would have been paid as Medicare DSH, adjusted for changes in the percentage of individuals that are uninsured. For FFY 2014, each Medicare DSH hospital's share of the UC DSH Amount pool is based on its share of insured low income days reported by all Medicare DSH hospitals.

During 2014, 64 of our acute care hospitals in continuing operations qualified for Medicare DSH payments. One of the variables used in the pre-ACA DSH formula is the number Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Original Medicare Plan patients, but also Medicare Advantage patients in the SSI ratio. The statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates ("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 in the FFY 2005 Final Rule. 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 in this regard; however, a favorable outcome of our DSH appeals could have a material impact on our future revenues and cash flows.

Direct Graduate and Indirect Medical Education Payments—The Medicare program provides additional reimbursement to approved teaching hospitals for additional expenses incurred by such institutions. This additional reimbursement,

which is subject to certain limits, including intern and resident full-time equivalent ("FTE") limits, is made in the form of Direct Graduate Medical Education ("DGME") and Indirect Medical Education ("IME") payments. During 2014, 28 of our hospitals in continuing operations were affiliated with academic institutions and were eligible to receive such payments.

Hospital Outpatient Prospective Payment System

Under the outpatient prospective payment system, hospital outpatient services, except for certain services that are reimbursed on a separate fee schedule, are classified into groups called ambulatory payment classifications

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("APCs"). Services in each APC are similar clinically and in terms of the resources they require, and a payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. CMS periodically updates the APCs and annually adjusts the rates paid for each APC.

Inpatient Psychiatric Facility Prospective Payment System

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

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility ("IRF") under the IRF prospective payment system ("IRF-PPS"). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system.

To be paid under the IRF-PPS, each hospital or unit must demonstrate on an annual basis that at least 60% of its total population had either a principal or secondary diagnosis that fell within one of 13 diagnosis categories or have qualifying conditions designated in the Medicare regulations governing IRFs. As of December 31, 2014, all of our rehabilitation units were in compliance with the required 60% threshold.

Physician Services Payment System

Medicare pays for physician and other professional services based on a list of services and their payment rates called the Medicare Physician Fee Schedule ("MPFS"). In determining payment rates for each service on the fee schedule, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations and other factors. The conversion factor updates payments for physician services every year according to a formula called the sustainable growth rate ("SGR") system in accordance with the Balanced Budget Act of 1997. This formula is intended to keep spending growth (a function of service volume growth) consistent with growth in the national economy. However, in the last several years, Congress has

specified an update outside of the SGR formula. Because of budget neutrality requirements, these payment updates have largely been funded by payment reductions to other providers, including hospitals.

Cost Reports

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

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

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Medicare Hospital Appeals Settlement

During the year ended December 31, 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 have accepted the settlement offer. The estimated cash value of the settlement for our hospitals' claims is approximately $19 million.

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, excluding state-funded managed care Medicaid programs, constituted approximately 9.4%, 9.0% and 8.4% of net patient revenues before provision for doubtful accounts of our continuing general hospitals for the years ended December 31, 2014, 2013 and 2012, respectively. We also receive DSH payments under various state Medicaid programs. For the years ended December 31, 2014, 2013 and 2012, our revenues attributable to DSH payments and other state-funded subsidy payments were approximately $817 million, $428 million and $283 million, respectively. The 2013 amount includes only three months of revenues related to the 28 hospitals we acquired from Vanguard on October 1, 2013.

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 or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted 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.

The Governor of California signed the Hospital Quality Assurance Fee ("HQAF") renewal bill into law in October 2013, extending California's provider fee program for three years beginning January 2014 (with a framework to renew the program for at least three additional years beyond 2016). During the three months ended December 31, 2014, CMS approved the 36-month HQAF program, and we recorded net revenues of approximately $165 million. Based on the most recent estimates from the California Hospital Association, the extension of the HQAF program authorized by the legislation will result in additional revenues for our hospitals, net of provider fees and other expenses, of approximately $530 million over the three-year period ending December 31, 2016.

During the three months ended December 31, 2012, certain of our Texas hospitals began to participate in the Texas 1115 demonstration waiver approved by CMS in December 2011 to replace the state's Upper Payment Limit program. The waiver term covers state fiscal years September 1, 2012 through August 31, 2016, is funded by intergovernmental transfer payments from local government entities, and includes two funding pools — Uncompensated Care and Delivery System Reform Payment. In 2014, we recognized $187 million of revenues from the Texas 1115 waiver programs. Separately, during the same period, we incurred $87 million of expenses related to funding indigent care services by certain of our Texas hospitals. We cannot provide any assurances as to the ultimate amount of revenues that our hospitals may receive from this program in 2015 and 2016.

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

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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 years ended December 31, 2014, 2013 and 2012 are set forth in the table below:

	Year Ended December 31,					
	2014(1)		2013		2012	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
Michigan	$ 337	$ 269	$ 64	$ 96	$ —	$ —
California	311	261	242	164	198	148
Texas	281	229	151	151	67	123
Florida	160	111	178	65	178	61
Illinois	80	31	33	6	—	—
Georgia	73	37	77	35	85	38
Pennsylvania	73	194	74	200	72	209
Missouri	67	9	64	6	70	5
Massachusetts	39	46	9	8	—	—
North Carolina	29	8	34	5	40	—
South Carolina	15	31	22	25	34	25
Alabama	12	—	13	—	31	—
Tennessee	7	29	5	27	8	29
Arizona	1	115	9	21	—	—
	$ 1,485	$ 1,370	$ 975	$ 809	$ 783	$ 638

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

Regulatory and Legislative Changes

The Medicare and Medicaid programs are subject to statutory and regulatory changes, administrative and judicial rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities. We are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid 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. Recent regulatory and legislative updates to the Medicare and Medicaid payment systems are provided below.

Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems. The updates generally become effective October 1, the beginning of the federal fiscal year. 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 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:

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- 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 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. 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.

Payment 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:

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A net payment increase 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 December 31, 2014, 22 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.

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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 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 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 December 31, 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.

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. 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 healthcare 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.

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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 from October 1, 2014 until at least 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” 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.

Medicare Claims Reviews

HHS estimates that approximately 10.1% of all Medicare Fee-For-Service (“FFS”) claim payments in FFY 2013 were improper, and HHS projects that the FFS improper payment rate will remain above 9.5% through FFY 2016. The Improper Payments Information Act of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010, requires the heads of federal agencies, including HHS, to annually review programs it administers to:

- Identify programs that may be susceptible to significant improper payments;

· Estimate the amount of improper payments in those programs;

· Submit those estimates to Congress; and

· Describe the actions the agency is taking to reduce improper payments in those programs.

CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS' stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. As a result, in addition to the Recovery Audit Contractor ("RAC") program, which currently performs post-payment claims reviews, CMS has recently established initiatives to prevent improper payments before a claim is processed. These initiatives include a significant increase in the number of prepayment claims reviews performed by MACs.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment claims denials are subject to administrative and judicial review. We have established robust protocols to respond to claims reviews and payment denials. Payment recoveries resulting from MAC reviews can be appealed through administrative and judicial processes, and we intend to pursue the reversal of adverse determinations where appropriate. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond

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to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

The American Recovery and Reinvestment Act of 2009

ARRA was enacted to stimulate the U.S. economy. One provision of ARRA provides financial incentives to hospitals and physicians to become “meaningful users” of electronic health records. The Medicare incentive payments to individual hospitals are made over a four-year, front-weighted transition period. The Medicaid incentive payments, which are administered by the states, are subject to more flexible payment and compliance standards than Medicare incentive payments; hospitals that achieve compliance between 2014 and 2015 will receive reduced incentive payments during the transition period.

We anticipate recognizing approximately $68 million of Medicare and Medicaid EHR incentive payments in 2015. In addition to the expenditures we incur to qualify for these incentive payments, our operating expenses have increased and we anticipate will increase in the future as a result of these information system investments. Eligible hospitals must continue to demonstrate meaningful use of EHR technology every year to avoid payment reductions in subsequent years. These reductions, which will be based on the market basket update, will be phased in over three years and will continue until a hospital achieves compliance. Should all of our hospitals fail to become meaningful users (or fail to continue to demonstrate meaningful use) of EHRs and fail to submit quality data, the penalties would result in reductions to our annual Medicare traditional inpatient net revenues of up to $30 million in 2016 and up to $50 million in 2017 and subsequent years.

During the year ended December 31, 2014, we recognized approximately $104 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of 54 of our hospitals and certain of our employed physicians demonstrating meaningful use of certified EHR technology. The final Medicare EHR incentive payments are determined when the cost report that begins in the federal fiscal year during which the hospital achieved meaningful use is settled. Medicare and Medicaid incentive payment amounts to which a provider is entitled are subject to post-payment audits.

The complexity of the changes required to our hospitals’ systems and the time required to complete the changes will likely result in some or all of our hospitals not being fully compliant in time to be eligible for the maximum HIT funding permitted under ARRA. Because of the uncertainties regarding the implementation of HIT, including CMS’ future EHR implementation regulations, the ability of our hospitals to achieve compliance and the associated costs, we cannot provide any assurances regarding the aforementioned estimates of incentives in 2015.

The American Taxpayer Relief Act of 2012

The American Taxpayer Relief Act of 2012 delayed by two months the effective date of the automatic reductions (referred to as “sequestration”) in federal spending, including a 2% reduction in Medicare payments, mandated by the Budget Control Act of 2011 that was originally scheduled to take effect on February 1, 2013. On March 1, 2013, the President signed an order to begin the sequestration. Subsequent legislation extended the sequestration adjustment through 2024. Effective April 1, 2013, all Medicare payments to providers began to be reduced by 2% and will continue to be paid at the reduced rate as long as the sequestration is in effect. As of December 31, 2014, Congress had not taken any action to reduce or eliminate the sequestration adjustment. Any such action would likely require other payments reductions in order to maintain budget neutrality. We cannot predict how long the sequestration will be in effect, nor can we predict what Medicare payment, eligibility and coverage changes, if any, will be enacted in lieu of the sequestration.

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MedPAC FFY 2015 Recommendations

Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems. Generally, the MedPAC opposes sequestration as a way to reduce payments, particularly below the base rate, because the MedPAC favors a more targeted approach to achieve savings. In January 2015, the MedPAC voted in favor of three recommendations for hospital inpatient and outpatient services, two of which affect acute care hospitals. Specifically, the MedPAC voted that Congress should direct HHS to:

- Reduce or eliminate the differences in payment rates between outpatient departments and physicians' offices for selected APCs; and

- Increase payment rates for the IPPS and OPPS in FFY 2015 by 3.25%.

We expect these recommendations to be included in the forthcoming MedPAC Annual Report to Congress. Congress is not obligated to adopt the MedPAC recommendations and, based on outcomes in previous years, there can be no assurance Congress will adopt such recommendations in a given year. We cannot predict what actions, if any, Congress, HHS or CMS will take with respect to the MedPAC recommendations or the effect, if any, of such actions on our net revenues or cash flows.

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 years ended December 31, 2014, 2013 and 2012 was $9.3 billion, $6.3 billion and $5.4 billion, respectively. Approximately 62% of our managed care net patient revenues for the year ended December 31, 2014 was derived from our top ten managed care payers. National payers generated approximately 48% of our total net managed care revenues. The remainder comes from regional or local payers. At December 31, 2014 and 2013 approximately 60% and 59%, 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

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plans. Based on reserves as of December 31, 2014, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have had improved year-over-year managed care pricing, we expect some moderation in the pricing percentage increases in future years. In the year ended December 31, 2014, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 71% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

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

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant 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. In the years prior to the implementation of the Affordable Care Act in 2014, we believe that our level of self-pay patients had been higher than previous periods due to a combination of broad economic factors, including increased unemployment rates, reductions in state Medicaid budgets, increasing numbers of individuals and

employers who chose 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 both December 31, 2014 and 2013, approximately 7% 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. 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 Conifer's operations. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of this report.

Conifer has performed systematic analyses to focus our attention on the drivers of bad debt expense for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate,

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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 had been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The following table shows our estimated costs (based on selected operating expenses) for caring for charity care patients and self-pay patients, as well as DSH payments we received, for the years ended December 31, 2014, 2013 and 2012.

	Years Ended December 31,		
	2014	2013	2012
Estimated costs for:			
Charity care patients	$ 180	$ 158	$ 136
Self-pay patients	$ 620	$ 545	$ 430
DSH payments received	$ 817	$ 428	$ 283

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 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 illegally who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

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RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2014 COMPARED TO THE YEAR ENDED DECEMBER 31, 2013

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 years ended December 31, 2014 and 2013:

	Years Ended December 31,		
	2014	2013	Increase (Decrease)
Net operating revenues:			
General hospitals	$ 15,843	$ 10,888	$ 4,955
Other operations	2,077	1,186	891
Net operating revenues before provision for doubtful accounts	17,920	12,074	5,846
Less provision for doubtful accounts	1,305	972	333
Net operating revenues	16,615	11,102	5,513
Operating expenses:			
Salaries, wages and benefits	8,023	5,371	2,652
Supplies	2,630	1,784	846
Other operating expenses, net	4,114	2,701	1,413
Electronic health record incentives	(104)	(96)	(8)
Depreciation and amortization	849	545	304
Impairment and restructuring charges, and acquisition-related costs	153	103	50
Litigation and investigation costs	25	31	(6)
Operating income	$ 925	$ 663	$ 262

	Years Ended December 31,		
	2014	2013	Increase (Decrease)
Net operating revenues	100.0 %	100.0%	100.0 %
Operating expenses:			
Salaries, wages and benefits	48.3 %	48.4 %	(0.1) %
Supplies	15.8 %	16.1 %	(0.3) %
Other operating expenses, net	24.8 %	24.3 %	0.5 %
Electronic health record incentives	(0.7) %	(0.9)%	0.2 %
Depreciation and amortization	5.1 %	4.9 %	0.2 %
Impairment and restructuring charges, and acquisition-related costs	0.9 %	0.9 %	— %
Litigation and investigation costs	0.2 %	0.3 %	(0.1) %

Operating income	5.6 %	6.0 %	(0.4) %

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. Revenues from our general hospitals represented approximately 88% and 90% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2014 and 2013, respectively.

Net operating revenues from our other operations were $2.077 billion and $1.186 billion in the years ended December 31, 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

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acquired from Vanguard and additional physician practices. Equity earnings for unconsolidated affiliates included in our net operating revenues from other operations were $12 million and $15 million for the years ended December 31, 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.

Selected Operating Statistics for All Continuing Operations Hospitals—The tables below show 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, TRMC, 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 the case of Vanguard, TRMC and Emanuel Medical Center, only for the period of time from acquisition to December 31, 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 Years Ended December 31,					
Admissions, Patient Days and Surgeries	2014		2013		Increase (Decrease)	
Total admissions	791,165		558,726		41.6	%
Adjusted patient admissions(1)	1,354,896		915,276		48.0	%
Paying admissions (excludes charity and uninsured)	745,462		518,239		43.8	%
Charity and uninsured admissions	45,703		40,487		12.9	%
Admissions through emergency department	495,195		347,920		42.3	%
Paying admissions as a percentage of total admissions	94.2	%	92.8	%	1.4	%(2)
Charity and uninsured admissions as a percentage of total admissions	5.8	%	7.2	%	(1.4)	%(2)
Emergency department admissions as a percentage of total admissions	62.6	%	62.3	%	0.3	%(2)
Surgeries — inpatient	215,660		155,634		38.6	%
Surgeries — outpatient	481,975		334,233		44.2	%
Total surgeries	697,635		489,867		42.4	%
Patient days — total	3,695,288		2,621,245		41.0	%
Adjusted patient days(1)	6,255,572		4,243,334		47.4	%
Average length of stay (days)	4.67		4.69		(0.4)	%
Number of hospitals (at end of period)	80		77		3	
Licensed beds (at end of period)	20,814		20,293		2.6	%
Average licensed beds	20,531		14,963		37.2	%
Utilization of licensed beds(3)	49.3	%	48.0	%	1.3	%(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 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.

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	Total Hospital Continuing Operations Years Ended December 31,					
Outpatient Visits	2014		2013		Increase (Decrease)	
Total visits	8,283,878		5,115,853		61.9	%
Paying visits (excludes charity and uninsured)	7,610,558		4,593,072		65.7	%
Charity and uninsured visits	673,320		522,781		28.8	%
Emergency department visits	2,824,526		1,865,239		51.4	%
Surgery visits	481,975		334,233		44.2	%
Paying visits as a percentage of total visits	91.9	%	89.8	%	2.1	%(1)
Charity and uninsured visits as a percentage of total visits	8.1	%	10.2	%	(2.1)	%(1)

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

	Total Hospital Continuing Operations Years Ended December 31,		
Revenues	2014	2013	Increase (Decrease)
Net operating revenues	$ 16,615	$ 11,102	49.7 %
Revenues from charity and the uninsured	$ 1,065	$ 778	36.9 %
Net inpatient revenues(1)	$ 10,015	$ 6,952	44.1 %
Net outpatient revenues(1)	$ 5,774	$ 3,859	49.6 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $393 million and $324 million for the years ended December 31, 2014 and 2013, respectively. Net outpatient revenues include self-pay revenues of $672 million and $454 million for the years ended December 31, 2014 and 2013, respectively.

	Total Hospital Continuing Operations Years Ended December 31,		
Revenues on a Per Admission, Per Patient Day and Per Visit Basis	2014	2013	Increase (Decrease)
Net inpatient revenue per admission	$ 12,659	$ 12,443	1.7 %

Net inpatient revenue per patient day	$ 2,710	$ 2,652	2.2 %
Net outpatient revenue per visit	$ 697	$ 754	(7.6) %
Net patient revenue per adjusted patient admission(1)	$ 11,653	$ 11,812	(1.3) %
Net patient revenue per adjusted patient day(1)	$ 2,524	$ 2,548	(0.9) %

(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.

	Total Hospital Continuing Operations Years Ended December 31,		
Provision for Doubtful Accounts	2014	2013	Increase (Decrease)
Provision for doubtful accounts	$ 1,305	$ 972	34.3 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	7.3 %	8.1 %	(0.8) %(1)

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

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	Total Hospital Continuing Operations Years Ended December 31,			
Selected Operating Expenses	2014	2013	Increase (Decrease)	
Hospital Operations and other				
Salaries, wages and benefits	$ 7,296	$ 4,795	52.2	%
Supplies	2,630	1,784	47.4	%
Other operating expenses	3,851	2,490	54.7	%
Total	$ 13,777	$ 9,069	51.9	%
Conifer				
Salaries, wages and benefits	$ 727	$ 576	26.2	%
Other operating expenses	263	211	24.6	%
Total	$ 990	$ 787	25.8	%
Total				
Salaries, wages and benefits	$ 8,023	$ 5,371	49.4	%
Supplies	2,630	1,784	47.4	%
Other operating expenses	4,114	2,701	52.3	%
Total	$ 14,767	$ 9,856	49.8	%
Rent/lease expense(1)				
Hospital Operations and other	$ 221	$ 172	28.5	%
Conifer	21	14	50.0	%
Total	$ 242	$ 186	30.1	%
Hospital Operations and other(2)				
Salaries, wages and benefits per adjusted patient day	$ 1,162	$ 1,128	3.0	%
Supplies per adjusted patient day	420	420	—	%
Other operating expenses per adjusted patient day	536	555	(3.4)	%
Total per adjusted patient day	$ 2,118	$ 2,103	0.7	%
Salaries, wages and benefits per adjusted patient admission	$ 5,365	$ 5,228	2.6	%
Supplies per adjusted patient admission	1,941	1,949	(0.4)	%
Other operating expenses per adjusted patient admission	2,473	2,574	(3.9)	%
Total per adjusted patient admission	$ 9,779	$ 9,751	0.3	%

(1) Included in other operating expenses.

(2) 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. These metrics exclude the expenses related to our health plans and our provider network based in Southern California that includes contracted independent physicians, ancillary providers and hospitals.

REVENUES

During the year ended December 31, 2014, our net operating revenues increased $5.513 billion, or 49.7%, compared to the year ended December 31, 2013. Hospital acquisitions contributed approximately $4.501 billion to the increase in our net operating revenues, while hospitals we operated throughout both periods contributed $1.012 billion, or additional revenues of 10.4%. The increase in total hospital net operating revenues is primarily due to higher inpatient and outpatient volumes, improved terms of our managed care contracts, $50 million of incremental net revenues from the California provider fee program ($165 million in 2014 compared to $115 million in 2013) and an increase in our other operations revenues. For the years ended December 31, 2014 and 2013, our net operating revenues attributable to DSH payments and other state-funded subsidy payments were approximately $817 million and $428 million, respectively.

During the year ended December 31, 2014, our net inpatient revenues increased $3.063 billion, or 44.1%, compared to the same period in 2013. Net inpatient revenues from hospital acquisitions contributed approximately

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$2.651 billion to the increase in our net inpatient revenues, while hospitals we operated throughout both periods contributed approximately $412 million, or 6.8% more revenues. Our total admissions increased 41.6% during the year ended December 31, 2014 compared to the year ended December 31, 2013 primarily due to our hospital acquisitions in 2014 and 2013 and organic growth. Admissions at hospitals we operated at the beginning of 2013 increased 3.0% in 2014 compared to 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. Net inpatient revenue per admission increased 1.7% for all continuing operations and 3.7% for hospitals we operated throughout 2014 and 2013, primarily due to the improved terms of our managed care contracts and incremental California provider fee program net revenues of our California hospitals operated at the beginning of 2013, which revenues were $150 million in 2014 compared to $115 million in 2013.

During the year ended December 31, 2014, our net outpatient revenues increased $1.915 billion, or 49.6%, and our total outpatient visits increased 61.9% compared to the same period in 2013. The growth in our outpatient revenues and volumes was related to both acquisitions and organic growth. Net outpatient revenues from acquisitions contributed approximately $1.599 billion to the increase in our net outpatient revenues, while facilities we operated throughout both periods contributed approximately $316 million, or 9.4% more revenues. The increase in total outpatient visits was primarily due to our acquisitions in 2014 and 2013. Outpatient visits associated with facilities we operated at the beginning of 2013 increased 6.6% in 2014 compared to 2013. Growth in outpatient revenues and volumes for facilities we operated throughout both periods was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program. Net outpatient revenue per visit decreased 7.6% for all continuing operations primarily due to the lower level of patient acuity at our recently opened or acquired facilities; however, net outpatient revenue per visit for facilities we operated throughout 2014 and 2013 increased 2.7%, primarily due to the improved terms of our managed care contracts.

Our Conifer subsidiary generated net operating revenues of $1.193 billion and $919 million during the years ended December 31, 2014 and 2013, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the 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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PROVISION FOR DOUBTFUL ACCOUNTS

The provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 7.3% for the year ended December 31, 2014 compared to 8.1% for the year ended December 31, 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 as a percentage of net operating revenues from 8.3% for the year ended December 31, 2013 to 6.5% for the year ended December 31, 2014 due to expansion of insurance coverage under the ACA, as well as the impact of favorable experience related to our estimated future recoveries in the 2014 period, partially offset by the impact of a greater amount of patient co-pays and deductibles and a 120 basis point decrease in our self-pay collection rate for the hospitals we operated throughout both periods. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2014 and December 31, 2013:

	December 31, 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	$ 323	$ —	$ 323	$ 301	$ —	$ 301
Medicaid	153	—	153	133	—	133
Net cost report settlements payable and valuation allowances	(51)	—	(51)	(75)	—	(75)
Managed care	1,528	99	1,429	1,179	69	1,110
Self-pay uninsured	578	482	96	344	290	54
Self-pay balance after insurance	210	133	77	224	141	83
Estimated future recoveries from accounts assigned to our Conifer subsidiary	125	—	125	92	—	92
Other payers	386	137	249	278	89	189
Total continuing operations	3,252	851	2,401	2,476	589	1,887
Total discontinued operations	4	1	3	3	—	3
	$ 3,256	$ 852	$ 2,404	$ 2,479	$ 589	$ 1,890

The increase in our total accounts receivable net of allowance for doubtful accounts from December 31, 2013 to December 31, 2014 is primarily related to the growth in hospital patient volumes, our outpatient development initiatives, a temporary buildup in accounts receivable of certain hospitals we acquired from Vanguard due to the implementation of a new billing system that is expected to enhance efficiency, growth in physician practices, the acquisition of TRMC and Emanuel Medical Center, and the opening of Resolute Health Hospital.

The increase in the allowance for doubtful accounts as a percentage of patient accounts receivable related to the accounts receivable acquired from Vanguard as of October 1, 2013. Under the purchase price allocation rules, allowance for doubtful accounts as of the acquisition date are offset against the gross receivables. As of the acquisition date, the acquirer begins to disclose the net receivable amount with no disclosure of the former allowance for doubtful accounts amount. Accounts receivable generated after the acquisition are disclosed before the allowance for doubtful accounts and the associated allowance for doubtful accounts is also disclosed to arrive at net accounts receivable. The increase also related to the 120 basis point decrease in our self-pay collection rate for the 49 hospitals we operated throughout the years ended December 31, 2014 and 2013, well as higher patient co-pays and deductibles, partially offset by a decline in uninsured revenues due to the expansion of insurance coverage under the Affordable Care Act.

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At December 31, 2014, our collection rate on self-pay accounts for hospitals we operated throughout 2014 and 2013 was approximately 27.5%. Our recent self-pay collection rates for hospitals we operated throughout all periods 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; 27.8% at June 30, 2014; and 27.5% at

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September 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 December 31, 2014, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $12 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 collection rate from managed care payers for hospitals we operated throughout 2014 and 2013 was approximately 98.3% at both December 31, 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. These initiatives 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 $2.452 billion and $1.962 billion at December 31, 2014 and 2013, respectively, excluding cost report settlements payable and valuation allowances of $51 million and $75 million at December 31, 2014 and 2013, respectively:

	December 31, 2014									
	Medicare		Medicaid		Managed Care		Indemnity, Self-Pay and Other		Total	
0-60 days	81	%	44	%	66	%	29	%	61	%
61-120 days	9	%	22	%	16	%	19	%	16	%
121-180 days	4	%	12	%	7	%	11	%	7	%
Over 180 days	6	%	22	%	11	%	41	%	16	%
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 49.5 days at December 31, 2014 and 44.7 days at December 31, 2013, within our target of less than 55 days. AR days at December 31, 2014 were negatively impacted by a temporary buildup in accounts receivable of certain hospitals acquired from Vanguard due to the implementation of a new billing system that is expected to enhance efficiency. 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.

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As of December 31, 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 recently 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 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 91% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid, compared to 93% during the three months ended December 31, 2013. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2014 and December 31, 2013 by aging category:

	December 31, 2014	December 31, 2013
0-60 days	$ 85	$