TENET HEALTHCARE CORP
Form 10-K
February 27, 2017
Table of Contents

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, 2016

OR

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

Commission File Number 1-7293

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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)

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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 % 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, 2016, 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 $1.9 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 31, 2017, there were 99,813,435 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2017 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

Table of Contents

TABLE OF CONTENTS

Table of Contents

PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as “Tenet,” “we” or “us”) is a diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks, primarily in large urban and suburban markets in the United States. At December 31, 2016, we operated 79 hospitals, 20 short-stay surgical hospitals, over 470 outpatient centers, and nine facilities in the United Kingdom through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. (“USPI joint venture”). In addition, our Conifer Holdings, Inc. (“Conifer”) subsidiary provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other, Ambulatory Care and Conifer. Additional information about our business segments is provided below, and financial and statistical data for the segments can be found in Item 7, Management’s Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

The healthcare industry, in general, and the acute care hospital business, in particular, are experiencing significant regulatory uncertainty based, in large part, on legislative efforts to significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (“Affordable Care Act” or “ACA”). It is difficult to predict the full impact of these actions on our future revenues and operations. However, we believe that our ultimate success in increasing our profitability depends in part on our success in executing the strategies discussed 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, these strategies are intended to address the following trends shaping the demand for healthcare services: (i) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (ii) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (iii) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (iv) consolidation continues across the entire healthcare sector through both traditional acquisition and divestiture activities, as well as joint ventures. Our ability to execute on our 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. 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.

Over the past several years, and with the aforementioned trends in mind, we have taken a number of steps to better position Tenet to compete more effectively in the ever evolving healthcare environment. We have set competitive prices for our services, made capital and other investments in our facilities and technology, increased our efforts to recruit and retain quality physicians, nurses and other healthcare personnel, and negotiated competitive contracts with managed care and other private payers. In addition, we have expanded our network of outpatient centers, and we have

increased the participation of our hospitals in accountable care organizations. We have also entered into joint ventures with other healthcare providers in several of our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum. Moreover, we are continuing our strategy of selling assets in non-core markets, such as our former hospitals and related operations in Georgia and North Carolina, as well as sub-scale businesses, such as our health plans. With respect to Conifer, we have added new clients in the revenue cycle and value-based care businesses and expanded engagements with existing clients.

## OPERATIONS

### HOSPITAL OPERATIONS AND OTHER SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—At December 31, 2016, our subsidiaries operated 79 hospitals, including three academic medical centers, two children's hospitals, two specialty hospitals and one critical access hospital, serving primarily urban and suburban communities in 12 states. Our subsidiaries had sole ownership of 62 of those hospitals, 14 were owned or leased by entities that are, in turn, jointly owned by a

Table of Contents

Tenet subsidiary and a healthcare system partner or group of physicians, and three were owned by third parties and leased by our wholly owned subsidiaries. Our Hospital Operations and other segment also included 177 outpatient centers at December 31, 2016, the majority of which are provider-based diagnostic imaging centers, freestanding urgent care centers, satellite emergency departments and provider-based ambulatory surgery centers. In addition, at December 31, 2016, our subsidiaries owned or leased and operated: a long-term acute care hospital; a number of medical office buildings, all of which were located on, or nearby, our hospital campuses; approximately 650 physician practices; accountable care networks; various health plans, which we intend to divest or wind down in 2017; and other ancillary healthcare businesses.

Our Hospital Operations and other segment generated approximately 86%, 91% and 94% of our consolidated net operating revenues for the years ended December 31, 2016, 2015 and 2014, respectively. 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) changes in federal and state healthcare regulations; (2) the business environment, economic conditions and demographics of local communities in which we operate; (3) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (4) seasonal cycles of illness; (5) climate and weather conditions; (6) physician recruitment, retention and attrition; (7) advances in technology and treatments that reduce length of stay; (8) local healthcare competitors; (9) managed care contract negotiations or terminations; (10) the number of patients with high-deductible health insurance plans; (11) any unfavorable publicity about us, or our joint venture partners, that affects our relationships with physicians and patients; 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 have intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals provide tertiary care services, such as open-heart surgery, neonatal intensive care and neurosciences, and some also offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Our children’s hospitals provide tertiary and quaternary pediatric services, including bone marrow and kidney transplants, as well as burn services. Moreover, a number of our hospitals offer advanced treatment options for patients, including limb-salvaging vascular procedures, acute level 1 trauma services, comprehensive intravascular stroke care, minimally invasive cardiac valve replacement, cutting edge imaging technology, and telemedicine access for selected medical specialties.

Except as set forth in the table below, each of our 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 wholly owned, operated as part of a joint venture, or leased and operated by our wholly owned subsidiaries at December 31, 2016:

| Hospital | Location | Licensed Beds | Status |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Alabama | | | |
| Brookwood Medical Center(1) | Birmingham | 607 | JV |
| Citizens Baptist Medical Center(1) | Talladega | 122 | JV |
| Princeton Baptist Medical Center(1) | Birmingham | 505 | JV |
| Shelby Baptist Medical Center(1) | Alabaster | 252 | JV |
| Walker Baptist Medical Center(1) | Jasper | 267 | JV |
| | | | |
| Arizona | | | |
| Abrazo Arizona Heart Hospital(2) | Phoenix | 59 | Owned |
| Abrazo Arrowhead Campus | Glendale | 217 | Owned |
| Abrazo Central Campus | Phoenix | 221 | Owned |
| Abrazo Maryvale Campus | Phoenix | 232 | Owned |
| Abrazo Scottsdale Campus | Phoenix | 136 | Owned |
| Abrazo West Campus | Goodyear | 188 | Owned |
| Holy Cross Hospital(3), (4) | Nogales | 25 | JV |
| St. Joseph's Hospital(3) | Tucson | 486 | JV |
| St. Mary's Hospital(3) | Tucson | 400 | JV |

Table of Contents

| Hospital | Location | Licensed Beds | Status |
|---|---|---|---|
| California | | | |
| Desert Regional Medical Center(5) | Palm Springs | 385 | Leased |
| Doctors Hospital of Manteca | Manteca | 73 | Owned |
| Doctors Medical Center | Modesto | 461 | Owned |
| Emanuel Medical Center | Turlock | 209 | Owned |
| Fountain Valley Regional Hospital and Medical Center | Fountain Valley | 400 | Owned |
| Hi-Desert Medical Center(6) | Joshua Tree | 179 | Leased |
| John F. Kennedy Memorial Hospital | Indio | 145 | Owned |
| Lakewood Regional Medical Center | Lakewood | 172 | Owned |
| Los Alamitos Medical Center | Los Alamitos | 167 | Owned |
| Placentia Linda Hospital | Placentia | 114 | Owned |
| San Ramon Regional Medical Center(7) | San Ramon | 123 | JV |
| Sierra Vista Regional Medical Center | San Luis Obispo | 164 | Owned |
| Twin Cities Community Hospital | Templeton | 122 | Owned |
| Florida | | | |
| Coral Gables Hospital | Coral Gables | 245 | Owned |
| Delray Medical Center | Delray Beach | 493 | Owned |
| Florida Medical Center – a campus of North Shore | Lauderdale Lakes | 459 | Owned |
| Good Samaritan Medical Center | West Palm Beach | 333 | Owned |
| Hialeah Hospital | Hialeah | 378 | Owned |
| North Shore Medical Center | Miami | 357 | Owned |
| Palm Beach Gardens Medical Center(8) | Palm Beach Gardens | 199 | Leased |
| Palmetto General Hospital | Hialeah | 368 | Owned |
| St. Mary’s Medical Center | West Palm Beach | 464 | Owned |
| West Boca Medical Center | Boca Raton | 195 | Owned |
| Illinois | | | |
| Louis A. Weiss Memorial Hospital | Chicago | 236 | Owned |
| MacNeal Hospital | Berwyn | 368 | Owned |
| West Suburban Medical Center | Oak Park | 234 | Owned |
| Westlake Hospital | Melrose Park | 230 | Owned |
| Massachusetts | | | |
| MetroWest Medical Center – Framingham Union Campus | Framingham | 147 | Owned |
| MetroWest Medical Center – Leonard Morse Campus | Natick | 152 | Owned |
| Saint Vincent Hospital | Worcester | 283 | Owned |
| Michigan | | | |
| Children’s Hospital of Michigan | Detroit | 228 | Owned |
| Detroit Receiving Hospital | Detroit | 273 | Owned |
| Harper University Hospital | Detroit | 470 | Owned |
| Huron Valley-Sinai Hospital | Commerce Township | 158 | Owned |

| | | | |
|---|---|---|---|
| Hutzel Women's Hospital | Detroit | 114 | Owned |
| Rehabilitation Institute of Michigan(2) | Detroit | 69 | Owned |
| Sinai-Grace Hospital | Detroit | 404 | Owned |

Table of Contents

| Hospital | Location | Licensed Beds | Status |
|---|---|---|---|
| Missouri | | | |
| Des Peres Hospital | St. Louis | 143 | Owned |
| Pennsylvania | | | |
| Hahnemann University Hospital | Philadelphia | 496 | Owned |
| St. Christopher’s Hospital for Children | Philadelphia | 189 | Owned |
| South Carolina | | | |
| Coastal Carolina Hospital | Hardeeville | 41 | Owned |
| East Cooper Medical Center | Mount Pleasant | 140 | Owned |
| Hilton Head Hospital | Hilton Head | 93 | Owned |
| Piedmont Medical Center | Rock Hill | 288 | Owned |
| Tennessee | | | |
| Saint Francis Hospital | Memphis | 479 | Owned |
| Saint Francis Hospital – Bartlett | Bartlett | 196 | Owned |
| Texas | | | |
| Baptist Medical Center | San Antonio | 623 | Owned |
| Baylor Scott & White Medical Center – Centennial(9), (10) | Frisco | — | JV |
| Baylor Scott & White Medical Center – Lake Pointe(10), (11) | Rowlett | — | JV |
| Baylor Scott & White Medical Center – Sunnyvale(10), (12) | Sunnyvale | — | JV |
| Baylor Scott & White Medical Center – White Rock(10), (13) | Dallas | — | JV |
| Cypress Fairbanks Medical Center | Houston | 181 | Owned |
| The Hospitals of Providence East Campus | El Paso | 182 | Owned |
| The Hospitals of Providence Memorial Campus | El Paso | 480 | Owned |
| The Hospitals of Providence Sierra Campus | El Paso | 329 | Owned |
| Houston Northwest Medical Center(14) | Houston | 423 | JV |
| Mission Trail Baptist Hospital | San Antonio | 110 | Owned |
| Nacogdoches Medical Center | Nacogdoches | 153 | Owned |
| North Central Baptist Hospital | San Antonio | 429 | Owned |
| Northeast Baptist Hospital | San Antonio | 371 | Owned |
| Park Plaza Hospital | Houston | 444 | Owned |
| Resolute Health | New Braunfels | 128 | Owned |
| St. Luke’s Baptist Hospital | San Antonio | 282 | Owned |
| Valley Baptist Medical Center | Harlingen | 586 | Owned |
| Valley Baptist Medical Center – Brownsville | Brownsville | 280 | Owned |
| Total Licensed Beds | | 20,354 | |

(1) Operated by a limited liability company formed as part of a joint venture with Baptist Health System, Inc. (“BHS”), a not-for-profit healthcare system in Alabama; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2016, and BHS owned a 40% interest.

(2) Specialty hospital.

(3) Owned by a limited liability company formed as part of a joint venture with Dignity Health and Ascension Arizona, each of which is a not-for-profit healthcare system; a Tenet subsidiary owned a 60% interest in the entity at December 31, 2016, Dignity Health owned a 22.5% interest and Ascension Arizona owned a 17.5% interest.

(4) 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.

(5) Lease expires in May 2027.

(6) Lease expires in July 2045.

(7) Owned by a limited liability company formed as part of a joint venture with John Muir Health ("JMH"), a not-for-profit healthcare system in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the entity at December 31, 2016, and JMH owned a 49% interest.

(8) Facility was leased at December 31, 2016; however, we exercised our purchase option under the lease in February 2016 and subsequently purchased the property in February 2017.

(9) Managed by a Tenet subsidiary and owned by a limited partnership that is owned by a limited liability partnership (the "JV LLP") formed as part of a joint venture with Baylor Scott & White Health ("BSW"), a not-for-profit healthcare system; at December 31, 2016, a Tenet subsidiary owned a 25% interest in the JV LLP, and BSW owned a 75% interest.

Table of Contents

(10) Although we manage the operations of this hospital, we have not included its licensed beds in the table because the statistical information associated with the hospital is not presented on a consolidated basis with our other facilities.
(11) Managed by a Tenet subsidiary and owned by a limited liability company in which the JV LLP (in which we own a 25% interest, as set forth in footnote (9) above) indirectly owned a 94.67% interest at December 31, 2016. As a result, our ownership interest in this facility is approximately 23.67%.
(12) Managed by a Tenet subsidiary and operated by a limited liability company in which the JV LLP (in which we own a 25% interest, as set forth in footnote (9) above) indirectly owned a 60.18% interest at December 31, 2016. As a result, our ownership interest in this facility is approximately 15%.
(13) Managed by a Tenet subsidiary and owned by the JV LLP (in which we own a 25% interest, as set forth in footnote (9) above).
(14) Owned by a limited liability company in which a Tenet subsidiary owned an 87.8% interest at December 31, 2016 and is the managing member.

Information regarding the utilization of licensed beds and other operating statistics at December 31, 2016, 2015 and 2014 can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

At December 31, 2016, our Hospital Operations and other segment also included 66 diagnostic imaging centers, 15 satellite emergency departments, 10 ambulatory surgery centers and six urgent care centers operated as departments of our hospitals and under the same license, as well as 80 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of eight diagnostic imaging centers, seven emergency hospitals (also known as microhospitals), four ambulatory surgery centers and 61 urgent care centers, the majority of which are managed by our USPI joint venture and operated under our national MedPost brand. Over half of the outpatient centers in our Hospital Operations and other segment at December 31, 2016 were in California, Florida and Texas, the same states where we had the largest concentrations of licensed hospital beds. Strong concentrations of hospital beds and outpatient centers within market areas may help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Accountable Care Networks—We own, control or operate 18 accountable care networks – in Alabama, Arizona, California, Florida, Illinois, Michigan, Missouri, Pennsylvania and Texas – and participate in four additional accountable care networks with other healthcare providers for select markets in Arizona, California, Massachusetts and Texas. An accountable care organization ("ACO") is a network of providers and suppliers that work together to invest in infrastructure and to redesign delivery processes in an effort to achieve high quality and efficient delivery of services. Because they promote accountability and coordination of care, ACOs are intended to produce savings as a result of improved quality and operational efficiencies. ACOs that achieve quality performance standards established by the U.S. Department of Health and Human Services ("HHS") are eligible to share in a portion of the amounts saved by the Medicare program. These networks operate using a range of payment and delivery models.

Health Plans—We recently announced our intention to sell or otherwise wind down our health plan businesses by the end of 2017 because they are not a core part of our long-term strategy and are sub-scale. Our health plans remain subject to numerous federal and state statutes and regulations related to their business operations, and each health plan continues to be licensed by one or more agencies in the states in which they conduct business. In addition, insurance regulators in several of the states in which we currently operate have required us to establish cash reserves in connection with certain of our health plans.

AMBULATORY CARE SEGMENT

Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our nine European Surgical Partners Limited (“Aspen”) facilities in the United Kingdom. The operations of our Ambulatory Care segment generated approximately 9% of our consolidated net operating revenues for the year ended December 31, 2016. At December 31, 2016, we had a 56.3% ownership interest in the USPI joint venture, while Welsh, Carson, Anderson & Stowe (“Welsh Carson”), a private equity firm that specializes in healthcare investments, owned approximately 41% through two subsidiaries, and Baylor University Medical Center (“Baylor”) owned approximately 3%. In January 2017, the subsidiaries of Welsh Carson delivered a put notice to us for the minimum number of shares (representing a 6.25% ownership interest in our USPI joint venture) that they are required to put to us in 2017 according to our put/call agreement. We expect that the closing of the put transaction will occur in the three months ending June 30, 2017 in accordance with the terms of the put/call agreement. We are currently evaluating the additional call options available to us pursuant to the put/call agreement. Also in January 2017, Baylor exercised its option to purchase an additional 1.99%

Table of Contents

of the total outstanding shares of the USPI joint venture from the subsidiaries of Welsh Carson. The closing of that transaction will occur following receipt of necessary regulatory approvals.

Our USPI Joint Venture's Business—Our USPI joint venture acquires and develops its facilities primarily through the formation of joint ventures with physicians and healthcare systems. Subsidiaries of the USPI joint venture hold ownership interests in the facilities directly or indirectly and operate the facilities on a day-to-day basis through management services contracts. We believe that this acquisition and development strategy and operating model will enable our USPI joint venture to continue to grow because of various industry trends we have seen emerge in recent years, namely that: (1) consumers are increasingly selecting services and providers based on cost and convenience, as well as quality; (2) more procedures are shifting from inpatient to outpatient settings; (3) payer reimbursements have become more closely tied to performance on quality and service metrics; and (4) healthcare providers are entering into joint ventures to maximize effectiveness, reduce costs and build clinically integrated networks.

The surgical facilities in our USPI joint venture primarily specialize in non-emergency cases and are licensed as ambulatory surgery centers, specialty hospitals or hospitals. We believe surgery centers and surgical hospitals offer many advantages to patients and physicians, including greater affordability, predictability and convenience. Medical emergencies at acute care hospitals often demand the unplanned use of operating rooms and result in the postponement or delay of scheduled surgeries, disrupting physicians' practices and inconveniencing patients. Outpatient facilities generally provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases. In addition, many physicians choose to perform surgery in outpatient facilities because their patients prefer the comfort of a less institutional atmosphere and the convenience of simplified admissions and discharge procedures.

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

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

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

At December 31, 2016, our USPI joint venture had interests in 239 ambulatory surgery centers, 34 urgent care centers operated under the CareSpot brand, 21 imaging centers and 20 short-stay surgical hospitals in 27 states. Of these 314 facilities, 177 are jointly owned with healthcare systems. As further described in Note 1 to our Consolidated

Table of Contents

Financial Statements, we do not consolidate the financial results of 108 of the facilities in which our USPI joint venture has an ownership interest, meaning that while we record a share of their net profit within our operating income as equity in earnings of unconsolidated affiliates, we do not include their revenues and expenses in the consolidated revenue and expense line items of our consolidated financial statements. Additional financial and other information about our Ambulatory Care operating segment can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

Aspen's Business—Aspen Healthcare's four acute care hospitals, one cancer center and four outpatient facilities offer patients in the United Kingdom a complete range of private healthcare and clinical services, including inpatient care, outpatient and minimally invasive treatment and surgery, and diagnostic imaging. As with our USPI joint venture, a number of Aspen's facilities are owned jointly with physicians and other health provider organizations.

CONIFER SEGMENT

Our Conifer subsidiary provides a number of services primarily to healthcare providers to assist them in generating improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. The operations of our Conifer segment generated approximately 5% of our consolidated net operating revenues for the year ended December 31, 2016.

Revenue Cycle Management—Conifer provides accounts receivable management, health information management, revenue integrity services 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 accreditation preparedness services;
- coding and compliance support, billing assistance, auditing, training and data management services at every step in the revenue cycle process;
- third-party billing and collections; and

· ongoing measurement and monitoring of key revenue cycle metrics.

These revenue cycle management solutions assist hospitals, physician practices and other healthcare organizations in improving cash flow, revenue, and 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. 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, 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

Table of Contents

aligning and managing financial incentives among healthcare stakeholders through risk modeling and management of 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.

Customers—At December 31, 2016, Conifer provided one or more of the business process services described above from 20 service centers to more than 800 Tenet and non-Tenet hospital and other clients in over 40 states. In 2012, we entered into agreements documenting the terms and conditions of various services Conifer provides to Tenet hospitals, as well as certain administrative services our Hospital Operations and other segment provides to Conifer. The pricing terms for the services provided by each party to the other under these contracts were based on estimated third-party pricing terms in effect at the time the agreements were signed. Prior to the expiration of these contracts in December 2018, we will undertake a new fair market value analysis with respect to the pricing of these services and use that analysis in our negotiation of renewal contracts. As a result, it is possible that the pricing under the renegotiated agreements may be different from the current agreements. In addition, Conifer has an agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 90 CHI hospitals through 2032. As further described in Note 15 to our Consolidated Financial Statements, CHI has a 23.8% ownership position in Conifer's principal operating subsidiary, Conifer Health Solutions, LLC.

For the year ended December 31, 2016, approximately 41% of Conifer's net operating revenues were attributable to its relationship with Tenet and approximately 35% were attributable to its relationship with CHI. The loss of CHI's business would have a material adverse impact on our Conifer segment, although not on Tenet as a whole. Additional financial and other information about our Conifer operating segment can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. We believe that our success in growing Conifer and increasing its profitability depends in part on our success in executing the following strategies: (1) attracting as new clients hospitals and other healthcare providers who currently handle their revenue cycle management processes internally; (2) generating new client relationships through opportunities from USPI and Tenet's acute care hospital corporate development activities; (3) expanding revenue cycle management and value-based care service offerings through organic development and small acquisitions; (4) leveraging data from tens of millions of patient interactions to capture new opportunities and service the value-based care environment to drive competitive differentiation; and (5) developing services for our Ambulatory Care segment, leveraging our USPI joint venture's capabilities. However, there can be no assurance that Conifer will be successful in generating new client relationships, particularly with respect to hospitals we or Conifer's other customers sell, as the respective buyers may not continue to use Conifer's services or, if they do, they may not do so under the same contractual terms.

REAL PROPERTY

The locations of our hospitals and the number of licensed beds at each hospital at December 31, 2016 are set forth in the table beginning on page 2. We lease the majority of our outpatient facilities in both our Hospital Operations and other segment and our Ambulatory Care segment. These leases typically have initial terms ranging from five to 20 years, and most of the leases contain options to extend the lease periods. Our subsidiaries also operate a number of medical office buildings, all of which are located on, or nearby, our hospital campuses. We own many of these medical office buildings; the remainder are owned by third parties and leased by our subsidiaries.

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

INTELLECTUAL PROPERTY

We rely on a combination of trademark, copyright and trade secret laws, as well as contractual terms and conditions, to protect our rights in our intellectual property assets. However, third parties may develop intellectual

Table of Contents

property that is similar or superior to ours. We also license third-party software, other technology and certain trademarks through agreements that impose specific restrictions on our ability to use the licensed items, such as prohibiting reverse engineering and limiting the use of copies with respect to licensed software. We control access to and use of our software and other technology through a combination of internal and external controls. Although we do not believe the intellectual property we utilize infringes any intellectual property right held by a third party, we could be prevented from utilizing such property and could be subject to significant damage awards if our use is found to do so.

## PHYSICIANS AND EMPLOYEES

Physicians—Our operations depend in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of our hospitals and who affiliate with us and use our facilities as an extension of their practices. Under state laws and other licensing standards, medical staffs are generally self-governing organizations subject to ultimate oversight by the facility's local governing board. Members of the medical staffs of our hospitals also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing facilities at any time. At December 31, 2016, we owned approximately 650 physician practices, and we employed (where permitted by state law) or otherwise affiliated with nearly 2,000 physicians; however, we have no contractual relationship with the overwhelming majority of the physicians who practice at our hospitals and outpatient centers. It is essential to our ongoing business that we attract an appropriate number of quality physicians in the specialties required to support our services and that we maintain good relations with those physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Moreover, our ability to recruit and employ physicians is closely regulated.

Employees—At December 31, 2016, we employed over 130,000 people (of which 23% were part-time employees) in our three business segments, as follows:

| | |
|---|---|
| Hospital Operations and other(1) | 98,500 |
| Ambulatory Care | 17,540 |
| Conifer | 15,570 |
| Total | 131,610 |

(1) Includes approximately 1,000 employees supporting the consolidated operations of our business.

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, which requires us to invest in their training.

Union Activity and Labor Relations—At December 31, 2016, approximately 23% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 34 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six expired contracts covering approximately 8% of our unionized employees and are negotiating renewals under extension agreements. We are also negotiating first contracts at three hospitals and one physician practice covering approximately 5% of our unionized employees where employees recently 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

Table of Contents

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. Organizing activities by labor unions could increase our level of union representation in future periods.

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

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

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

Another major factor in the competitive position of a hospital or outpatient facility is the ability to negotiate contracts with managed care plans. Health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), third-party administrators, and other third-party payers use managed care contracts to encourage patients to use certain hospitals in exchange for discounts from the hospitals’ established charges. Our future success depends, in part, on our

ability to retain and renew our managed care contracts and enter into new managed care contracts on competitive terms. Other healthcare providers may affect our ability to enter into acceptable managed care contractual arrangements or negotiate increases in our reimbursement. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Furthermore, the trend toward consolidation among non-government payers tends to increase their bargaining power over fee structures.

In addition, the competitive position of hospitals and outpatient facilities is dependent in significant part on the number, quality, specialties, and admitting and scheduling practices of the licensed physicians who have been admitted to the medical staffs of the hospitals and who affiliate with and use outpatient facilities as an extension of their practices. Members of the medical staffs of our hospitals also often serve on the medical staffs of facilities we do not operate, and they are free to terminate their association with our hospitals or admit their patients to competing facilities at any time.

State laws that require findings of need for construction and expansion of healthcare facilities or services (as described in “Healthcare Regulation and Licensing — Certificate of Need Requirements” below) may also 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.

Table of Contents

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

We have made significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of other physicians on the medical staff, the location of the hospital, and the quality of the hospital's facilities, equipment and employees. In addition, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in 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 effects of: (1) reducing costs; (2) increasing payments from Medicare and certain managed care payers for our services as governmental and private payers move to pay-for-performance models, and the commercial market moves to more narrow networks and other methods designed to encourage covered individuals to use certain facilities over others; and (3) increasing physician and patient satisfaction, which may improve our volumes.

Moreover, in several markets, we have formed clinically integrated organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model. However, we do face competition from other healthcare systems that are implementing similar physician alignment strategies, such as employing physicians, acquiring physician practice groups, and participating in ACOs or other clinical integration models.

REVENUE CYCLE MANAGEMENT SOLUTIONS

Our Conifer subsidiary faces competition from existing participants and new entrants to the revenue cycle management market, some of which may have significantly greater capital resources than Conifer. In addition, the internal revenue cycle management staff of hospitals and other healthcare providers, who have historically performed many of the functions addressed by our services, in effect compete with us. Moreover, providers who have previously made investments in internally developed solutions may choose to continue to rely on their own resources. We also currently compete with several categories of external participants in the revenue cycle market, 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; and (7) financial resources to maintain current technology and other infrastructure.

Table of Contents

Conifer has pursued a program to attract additional clients and diversify its client base. 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 customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition has resulted and may continue to result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

## HEALTHCARE REGULATION AND LICENSING

### HEALTHCARE REFORM

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

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

In January 2017, some members of Congress began renewed efforts to modify, repeal or otherwise invalidate all or significant portions of the ACA. In addition, the President issued an executive order on January 20, 2017 declaring that the official policy of his administration will be to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations.

We cannot predict if or when modification or repeal of the ACA will take effect or what action, if any, Congress might take with respect to replacing the law. We are also unable to predict the impact of legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare disproportionate share hospital ("DSH") payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in federal fiscal year ("FFY") 2018) are made.

ANTI-KICKBACK AND SELF-REFERRAL REGULATIONS

Anti-Kickback Statute—Medicare and Medicaid anti-kickback and anti-fraud and abuse amendments codified under Section 1128B(b) of the Social Security Act (the "Anti-kickback Statute") prohibit certain business practices and relationships that might affect the provision and cost of healthcare services payable under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. Specifically, the law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. In addition to addressing other

Table of Contents

matters, as discussed below, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") also amended Title XI (42 U.S.C. Section 1301 et seq.) to broaden the scope of fraud and abuse laws to include all health plans, whether or not payments under such health plans are made pursuant to a federal program. Moreover, the Affordable Care Act, which remains law at this time, amended the Anti-kickback Statute to provide that intent to violate the Anti-kickback Statute is not required; rather, intent to violate the law generally is all that is required.

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

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

Stark Law—The Stark law generally restricts referrals by physicians of Medicare or Medicaid patients to entities with which the physician or an immediate family member has a financial relationship, unless one of several exceptions applies. The referral prohibition applies to a number of statutorily defined "designated health services," such as clinical laboratory, physical therapy, radiology, and inpatient and outpatient hospital services; the prohibition does not apply to health services provided by an ambulatory surgery center if those services are included in the surgery center's composite Medicare payment rate. However, if the ambulatory surgery center is separately billing Medicare for designated health services that are not covered under the ambulatory surgery center's composite Medicare payment rate, or if either the ambulatory surgery center or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ambulatory surgery center service, the Stark law's self-referral prohibition would apply and such services could implicate the Stark law. Exceptions to the Stark law's referral prohibition cover a broad range of common financial relationships. These statutory and the subsequent regulatory exceptions are available to protect certain permitted employment relationships, relocation arrangements, leases, group practice arrangements, medical directorships, and other common relationships between physicians and providers of designated health services, such as hospitals. A violation of the Stark law may result in a denial of payment, required refunds to patients and the Medicare program, civil monetary penalties of up to $15,000 for each violation, civil monetary penalties of up to $100,000 for "sham" arrangements, civil

monetary penalties of up to $10,000 for each day that an entity fails to report required information, and exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, the submission of a claim for services or items generated in violation of the Stark law may constitute a false or fraudulent claim, and thus be subject to additional penalties under the FCA. Many states have adopted self-referral statutes similar to the Stark law, some of which extend beyond the related state Medicaid program to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care. Our participation in and development of joint ventures and other financial relationships with physicians could be adversely affected by the Stark law and similar state enactments.

The Affordable Care Act also made changes to the “whole hospital” exception in the Stark law, effectively preventing new physician-owned hospitals after March 23, 2010 and limiting the capacity and amount of physician ownership in 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

Table of Contents

and a Medicare provider agreement as of March 23, 2010 (or, for those hospitals under development at the time of the ACA's enactment, as of December 31, 2010). A physician-owned hospital that meets these requirements is still subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for hospitals with a high percentage of Medicaid patients, prohibit expansion of the number of operating rooms, procedure rooms or beds. Physician-owned hospitals are also currently subject to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements.

Implications of Fraud and Abuse Laws—At December 31, 2016, three of our hospitals in our Hospital Operations and other segment, and the majority of the facilities that operate as hospitals in our Ambulatory Care segment, are owned by joint ventures that include some physician owners and are subject to the limitations and requirements in the Affordable Care Act on physician-owned hospitals. Furthermore, the majority of ambulatory surgery centers in our Ambulatory Care segment, which are owned by joint ventures with physicians or healthcare systems, are subject to the Anti-kickback Statute and, in certain circumstances, may be subject to the Stark law. In addition, we have contracts with physicians and non-physician referral services providing for a variety of financial arrangements, including employment contracts, leases and professional service agreements, such as medical director agreements. We have also provided financial incentives to recruit physicians to relocate to communities served by our hospitals, including income and collection guarantees and reimbursement of relocation costs, and will continue to provide recruitment packages in the future. Furthermore, new payment structures, such as ACOs and other arrangements involving combinations of hospitals, physicians and other providers who share payment savings, could potentially be seen as implicating anti-kickback and self-referral provisions.

Our operations could be adversely affected by the failure of our arrangements to comply with the Anti kickback Statute, the Stark law, billing requirements, current state laws, or other legislation or regulations in these areas adopted in the future. We are unable to predict whether other legislation or regulations at the federal or state level in any of these areas will be adopted, what form such legislation or regulations may take or how they may impact our operations. For example, we cannot predict whether physicians may ultimately be restricted from holding ownership interests in hospitals or whether the exception relating to services provided by ambulatory surgery centers could be eliminated. We are continuing to enter into new financial arrangements with physicians and other providers in a manner we believe complies in all material respects with applicable anti-kickback and anti-fraud and abuse laws. However, governmental officials responsible for enforcing these laws may nevertheless assert that we are in violation of these provisions. In addition, these statutes or regulations may be interpreted and enforced by the courts in a manner that is not consistent with our interpretation. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, 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 our USPI joint venture or its subsidiaries has violated any of these laws could give certain of our healthcare system partners a right to terminate their relationships with us; and any similar determination with respect to Conifer or any of its subsidiaries could give Conifer's customers the right to terminate their services agreements with us. Moreover, any violations by and resulting penalties or exclusions imposed upon our USPI joint venture's healthcare system partners or Conifer's customers could adversely affect their financial condition and, in turn, have a material adverse effect on our business and results of operations.

Retention of Independent Compliance Monitor—As previously disclosed, in September 2016, one of our subsidiaries, Tenet HealthSystem Medical, Inc. ("THSMI"), entered into a Non-Prosecution Agreement ("NPA") with the Criminal Division, Fraud Section, of the U.S. Department of Justice ("DOJ") and the U.S. Attorney's Office for the Northern District of Georgia (together, the "Offices"). The NPA requires, among other things, (i) THSMI and the Company to fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, and (ii) the Company to retain an independent compliance monitor to assess, oversee and monitor its compliance with the obligations under the NPA. On February 1, 2017, the Company retained two independent co-monitors (the "Monitor"), who are partners in a national law firm.

The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained). However, in the event the Offices determine, in their sole discretion, that the Company, or any of its subsidiaries or affiliates, has knowingly violated any provision of the NPA, the NPA could be extended by the Offices,

Table of Contents

in their sole discretion, for up to one year, without prejudice to the Offices' other rights under the NPA. Conversely, in the event the Offices find, in their sole discretion, that there exists a change in circumstances sufficient to eliminate the need for a monitor, or that the other provisions of the NPA have been satisfied, the oversight of the Monitor or the NPA itself may be terminated early.

The Monitor's primary responsibility is to assess, oversee and monitor the Company's compliance with its obligations under the NPA, so as to specifically address and reduce the risk of any recurrence of violations of the Anti-kickback Statute and Stark law (collectively, "Misconduct") by any entity the Company owns, in whole or in part. In doing so, the Monitor will review and monitor the effectiveness of the Company's compliance with the Anti-kickback Statute and the Stark law, as well as respective implementing regulations, advisories and advisory opinions promulgated thereunder, and make such recommendations as the Monitor believes are necessary to comply with the NPA. With respect to all entities in which the Company or one of its affiliates owns a direct or indirect equity interest of 50% or less and does not manage or control the day-to-day operations, the Monitor's access to such entities shall be co-extensive with the Company's access or control and for the purpose of reviewing the conduct. During its term, the Monitor will review and provide recommendations for improving compliance with the Anti-kickback Statute and Stark law, as well as the design, implementation and enforcement of the Company's compliance and ethics programs for the purpose of preventing future criminal and ethical violations by the Company and its subsidiaries, including, but not limited to, violations related to the conduct giving rise to the NPA and the Criminal Information filed in connection with the NPA. For additional information regarding the duties and authorities of the Monitor, reference is made to the Company's Current Report on Form 8-K filed on October 3, 2016.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

To receive reimbursement from CMS for electronic claims, healthcare providers and health plans must use HIPAA's electronic data transmission (transaction and code set) standards when transmitting certain healthcare information electronically. Effective October 1, 2015, CMS changed the formats used for certain electronic transactions and began requiring the use of updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. Although use of the ICD-10 code sets required significant modifications to our payment systems and processes, the costs 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. Furthermore, our electronic data transmissions are compliant with current HHS standards for additional electronic transactions and with HHS' operating rules to promote

uniformity in the implementation of each standardized electronic transaction.

Under HIPAA, covered entities must establish administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic PHI maintained or transmitted by them or by others on their behalf. The covered entities we operate are in material compliance with the privacy, security and National Provider Identifier requirements of HIPAA. In addition, most of Conifer's 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

Table of Contents

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 (as well as contractual liability to the associated covered entity), 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.

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 U.S.-based employees. Based on existing regulations and our experience with HIPAA to this point, we continue to believe that the ongoing costs of complying with HIPAA will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

GOVERNMENT ENFORCEMENT EFFORTS AND QUI TAM LAWSUITS

Both federal and state government agencies continue heightened and coordinated civil and criminal enforcement efforts against the healthcare industry. The 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, these policies and procedures may not be effective.

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. It is a violation of the FCA to knowingly fail to report and return an overpayment within 60 days of identifying the

overpayment or by the date a corresponding cost report is due, whichever is later. Qui tam actions can also be filed under certain state false claims laws if the fraud involves Medicaid funds or funding from state and local agencies.

As previously disclosed, in September 2016, the Company and certain of its subsidiaries, including THSMI, Atlanta Medical Center, Inc. (“AMCI”) and North Fulton Medical Center, Inc. (“NFMCI”), executed agreements with the DOJ and others to resolve a civil qui tam action and criminal investigation. In accordance with the terms of the resolution agreements, AMCI and NFMCI pled guilty before the U.S. District Court for the Northern District of Georgia to conspiring to violate the Anti-kickback Statute and defraud the United States. In addition, in accordance with the resolution agreements, AMCI and NFMCI paid forfeiture money judgments in the total amount of approximately $146 million to the United States, and the Company paid approximately $372 million to resolve the civil qui tam litigation. If we are alleged or found to have violated the terms of the NPA described above or federal healthcare laws, rules or regulations in the future, our business, financial condition, results of operations or cash flows could be materially adversely affected. We may be required to defend qui tam actions in the future, and we are unable to predict the impact of such actions on our business, financial condition, results of operations or cash flows.

Table of Contents

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

There has been increased scrutiny from outside auditors, government enforcement agencies and others, as well as an increased risk of government investigations and qui tam lawsuits, related to hospitals’ Medicare observation rates and inpatient admission decisions. The term “Medicare observation rate” is defined as total unique observation claims divided by the sum of total unique observation claims and total inpatient short-stay acute care hospital claims. A low rate may raise suspicions that a hospital is inappropriately admitting patients that could be cared for in an observation setting. In addition, CMS has established a concept referred to as the “two-midnight rule” to guide practitioners admitting patients and contractors on when it is appropriate to admit individuals as hospital inpatients. Under the two-midnight rule, full implementation and enforcement of which began on January 1, 2016, 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; if not, the patient generally should be treated as an outpatient, unless an exception applies. In our affiliated hospitals, we conduct reviews of Medicare inpatient stays of less than two midnights to determine whether a patient qualifies for inpatient admission. 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 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

Table of Contents

expenditures exceeding a prescribed amount, changes in bed capacity or services, and certain other matters. Our subsidiaries operate hospitals in eight states that require a form of state approval under certificate of need programs applicable to those hospitals. Approximately 49% of our licensed hospital beds are located in these states (namely, Alabama, Florida, Illinois, Massachusetts, Michigan, Missouri, South Carolina and Tennessee). The certificate of need programs in most of these states, along with several others, also apply to ambulatory surgery centers.

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

ENVIRONMENTAL MATTERS

Our healthcare operations are subject to a number of federal, state and local environmental laws, rules and regulations that govern, among other things, our disposal of solid waste, as well as our use, storage, transportation and disposal of hazardous and toxic materials (including radiological materials). Our operations also generate medical waste that must be disposed of in compliance with statutes and regulations that vary from state to state. In addition, although we are not engaged in manufacturing or other activities that produce meaningful levels of greenhouse gas emissions, our operating expenses could be adversely affected if legal and regulatory developments related to climate change or other initiatives result in increased energy or other costs. We could also be affected by climate change and other environmental issues to the extent such issues adversely affect the general economy or result in severe weather affecting the communities in which our facilities are located. At this time, based on current climate conditions and our assessment of existing and pending environmental rules and regulations, as well as treaties and international accords relating to climate change, we do not believe that the costs of complying with environmental laws, including regulations relating to climate change issues, will have a material adverse effect on our future capital expenditures, results of operations or cash flows. There were no material capital expenditures for environmental matters in the year ended December 31, 2016.

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 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 statutes and regulations regarding their consumer finance, debt collection and credit reporting activities.

Table of Contents

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. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt. In addition, the FDCPA contains various notice and disclosure requirements and 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 manages for its clients 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. State credit reporting laws, to the extent they are not preempted by the FCRA, may also apply to SOS.

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.

Conifer and its subsidiaries are also subject to regulation by the Federal Trade Commission and the U.S. Consumer Financial Protection Bureau ("CFPB"). Both the FTC and the CFPB have the authority to investigate consumer complaints relating to a variety of consumer protection laws, including the FDCPA, FCRA and FACTA, and to initiate enforcement actions, including actions to seek restitution and monetary penalties from, or to require changes in business practices of, regulated entities. 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.

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, USPI joint venture and Conifer offices, hospitals, outpatient centers, health plan offices and physician practices meet or exceed applicable standards established by federal and state statutes and regulations, as well as industry practice, and (2) monitor and raise awareness of ethical

Table of Contents

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

- 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 statutes and regulations as a foundation of its corporate philosophy, and (3) aligns its behaviors and decisions with Tenet's core values of quality, integrity, service, innovation and transparency.

The primary focus of our quality, compliance and ethics program is compliance with the requirements of Medicare, Medicaid and other federally funded healthcare programs. Pursuant to the terms of the charter, our ethics and compliance department is responsible for, among other things, the following activities: (1) ensuring, in collaboration with Tenet's law department, facilitation of the Monitor's activities and compliance with the provisions of the NPA and related Tenet policies; (2) assessing, critiquing, and (as appropriate) drafting and distributing company policies and procedures; (3) developing, providing, and tracking ethics and compliance training and other training programs, including job-specific training to those who work in clinical quality, coding, billing, cost reporting and referral source arrangements, in collaboration with the respective department responsible for oversight of each of these areas; (4) creating and disseminating the Company's Standards of Conduct and obtaining certifications of adherence to the Standards of Conduct as a condition of employment; (5) maintaining and promoting Tenet's Ethics Action Line, a 24-hour, toll-free hotline that allows for confidential reporting of issues on an anonymous basis and emphasizes the Company's no-retaliation policy; and (6) responding to and ensuring resolution of all compliance-related issues that arise from the Ethics Action Line and compliance reports received from facilities and compliance officers (utilizing any compliance reporting software that the Company may employ for this purpose) or any other source that results in a report to the ethics and compliance department.

Standards of Conduct—All of our employees, including our chief executive officer, chief financial officer and principal accounting officer, are required to abide by our Standards of Conduct to advance our mission that our business be conducted in a legal and ethical manner. The members of our board of directors and 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 statutes and regulations, appropriate use of our assets, protection of patient information and avoidance of conflicts of interest.

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

Non-Prosecution Agreement—As previously disclosed, in September 2016, our THSMI subsidiary entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia. The NPA requires, among other things, that we and THSMI (i) fully cooperate with the

Table of Contents

Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, (ii) retain an independent compliance monitor to assess, oversee and monitor our compliance with the obligations under the NPA, (iii) promptly report any evidence or allegations of actual or potential violations of the Anti-kickback Statute, (iv) maintain our compliance and ethics program throughout our operations, including those of our subsidiaries, affiliates, agents and joint ventures (to the extent that we manage or control or THSMI manages or controls such joint ventures), and (v) notify the DOJ and undertake certain other obligations specified in the NPA relative to, among other things, any sale, merger or transfer of all or substantially all of our and THSMI's respective business operations or the business operations of our or its subsidiaries or affiliates, including an obligation to include in any contract for sale, merger, transfer or other change in corporate form a provision binding the purchaser to retain the commitment of us or THSMI, or any successor-in-interest thereto, to comply with the NPA obligations except as may otherwise be agreed by the parties to the NPA in connection with a particular transaction. The powers, duties and responsibilities of the independent compliance monitor are broadly defined.

The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained), but it may be extended or terminated early as described herein and in the NPA. If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal health care programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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. A copy of the NPA is attached as an exhibit to our Current Report on Form 8-K filed with the SEC on October 3, 2016.

## INSURANCE

Property Insurance—We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis. For the policy period April 1, 2016 through March 31, 2017, we have coverage totaling $600 million per occurrence, after deductibles and exclusions, with annual aggregate sub-limits of $100 million each for floods and earthquakes and a per-occurrence sub-limit of $200 million for windstorms with no

annual aggregate. With respect to fires and other perils, excluding floods, earthquakes and windstorms, the total $600 million limit of coverage per occurrence applies. Deductibles are 5% of insured values up to a maximum of $25 million for floods, California earthquakes and wind-related claims, and 2% of insured values for New Madrid fault earthquakes, with a maximum per claim deductible of $25 million. Other covered losses, including fires and other perils, have a minimum deductible of $1 million.

Professional and General Liability Insurance—As is typical in the healthcare industry, we are subject to claims and lawsuits in the ordinary course of business. The healthcare industry has seen significant increases in the cost of professional liability insurance due to increased litigation. In response, we maintain captive insurance companies to self-insure a substantial portion of our professional and general liability risk. We also own 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

Table of Contents

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.

## EXECUTIVE OFFICERS

Information about our executive officers, as of February 27, 2017, is as follows:

| Name | Position | Age |
|---|---|---|
| Trevor Fetter | Chairman, President and Chief Executive Officer | 57 |
| Daniel J. Cancelmi | Chief Financial Officer | 54 |

| | | |
|---|---|---|
| Keith B. Pitts | Vice Chairman | 59 |
| J. Eric Evans | President of Hospital Operations | 39 |
| Audrey T. Andrews | Senior Vice President and General Counsel | 50 |

Mr. Fetter was named Tenet's president in November 2002; he was appointed chief executive officer in September 2003 and chairman in May 2015. From March 2000 to November 2002, Mr. Fetter was chairman and chief executive officer of Broadlane, Inc. From October 1995 to February 2000, he served in several senior management positions at Tenet, including chief financial officer. Mr. Fetter began his career with Merrill Lynch Capital Markets, where he concentrated on corporate finance and advisory services for the entertainment and healthcare industries. In 1988, he joined Metro-Goldwyn-Mayer, Inc., where he had a broad range of corporate and operating responsibilities, rising to executive vice president and chief financial officer. Mr. Fetter holds a bachelor's degree in economics from Stanford University and an M.B.A. from Harvard Business School. He is a member of the board of directors of one other public company, The Hartford Financial Services Group, Inc. Mr. Fetter also serves on the board of directors of the Federation of American Hospitals, the board of Dean's Advisors of the Harvard Business School, the Smithsonian National board and the Dallas Citizens Council board.

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

Table of Contents

Duquesne University in Pittsburgh. He is also a member of the American Institute of Certified Public Accountants and the Florida and Pennsylvania Institutes of Certified Public Accountants.

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

Mr. Evans was appointed Tenet's president of hospital operations in March 2016. He previously served as chief executive officer of our Texas Region from April 2015 and as market chief executive officer of The Hospitals of Providence (formerly known as the Sierra Providence Health Network) in El Paso from September 2012. Mr. Evans was the chief executive officer of the Dallas-area Lake Pointe Health Network from September 2010, where he previously held the positions of chief operating officer and director of business development after he joined Tenet in August 2004 as part of our MBA Leadership Development Program. He also served as vice president in Tenet's executive office and chief of staff from June 2009 to September 2010. Earlier in his career, Mr. Evans was an industrial engineer and a material flow coordinator at Saturn Corporation, a former subsidiary of General Motors Co. He holds a bachelor's degree in industrial management from Purdue University and an M.B.A. from Harvard Business School. He is also a fellow in the American College of Healthcare Executives. Beginning in 2014, Mr. Evans served a three-year term as a member of the board of directors of the El Paso Branch of the Federal Reserve Bank of Dallas, for which he acted as chair in 2016.

Ms. Andrews was appointed senior vice president and general counsel in January 2013. From July 2008 until that appointment, she served as senior vice president and chief compliance officer and, prior to that, served as vice president and chief compliance officer from November 2006. She joined Tenet in 1998 as hospital operations counsel. Ms. Andrews holds a J.D. and a bachelor's degree in government, both from the University of Texas at Austin. She is a member of the American and Texas Bar Associations and the American Health Lawyers Association.

## FORWARD-LOOKING STATEMENTS

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

occur in the future are forward-looking statements. These forward-looking statements represent management's current expectations, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors – many of which we are unable to predict or control – that may cause our actual results, performance or achievements, or healthcare industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the following:

· The timing and impact on our business of the repeal or significant modification of the Affordable Care Act, the enactment of a replacement omnibus healthcare law, if any, and the enactment of, or changes in, other statutes and regulations affecting the healthcare industry generally;

· 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 regulatory developments, government investigations or litigation;

Table of Contents

- Adverse developments with respect to our ability to comply with the terms of the Non-Prosecution Agreement;

- Our ability to enter into managed care provider arrangements on acceptable terms, including our ability to mitigate the impact of national managed care contracts that expire and are not replaced;

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

- Competition;

- Increases in wages and our ability to hire and retain qualified personnel, especially healthcare professionals;

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

- Our ability to continue to expand and realize earnings contributions from our Ambulatory Care and Conifer segments;

- Our ability to achieve operating and financial targets, attain expected levels of patient volumes, and identify and execute on measures designed to save or control costs or streamline operations;

- Our success in divesting sub-scale businesses, such as our health plans, and completing other corporate development transactions;

- Increases in the amount and risk of collectability of uninsured accounts and deductibles and copays for insured accounts;

- Changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under managed care agreements;

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

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

When considering forward-looking statements, 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 statement. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

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

Table of Contents

ITEM 1A. RISK FACTORS

Our business is subject to a number of risks and uncertainties – many of which are beyond our control – that may cause our actual operating results or financial performance to be materially different from our expectations. If one or more of the events discussed in this report were to occur, actual outcomes could differ materially from those expressed in or implied by any forward-looking statements we make in this report or our other filings with the SEC, and our business, financial condition, results of operations or liquidity could be materially adversely affected; furthermore, the trading price of our common stock could decline and our shareholders could lose all or part of their investment.

We cannot predict the timing or outcome of Congress' plan to significantly modify or repeal the Affordable Care Act or what action, if any, legislators may take to replace the law, nor are we able to predict the ultimate effect that such actions may have on our business, financial condition, results of operations or cash flows.

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities with either private or public program coverage and a decrease in uninsured and charity care admissions. Although a substantial portion of both our patient volumes and, as result, our revenues has historically been derived from government healthcare programs, reductions to our reimbursement under the Medicare and Medicaid programs as a result of the ACA have been partially offset by increased revenues from providing care to previously uninsured individuals. In January 2017, some members of Congress began renewed efforts to modify, repeal or otherwise invalidate all or significant portions of the ACA. In addition, the President issued an executive order on January 20, 2017 declaring that the official policy of his administration will be to seek the prompt repeal of the ACA and directing the heads of all executive departments and agencies to minimize the economic and regulatory burdens of the ACA to the maximum extent permitted by law while the ACA remains in effect. The White House also sent a memorandum to federal agencies directing them to freeze any new or pending regulations.

We cannot predict if or when modification or repeal of the ACA will take effect or what action, if any, Congress might take with respect to replacing the law. We are also unable to predict the impact of legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in FFY 2018) are made.

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, 2016 was $11.2 billion, which represented approximately 62% of our total net patient revenues before provision for doubtful accounts. Approximately 61% of our managed care net patient revenues for the year ended December 31, 2016 was derived from our top ten managed care payers. In the year ended December 31, 2016, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 77% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans. In addition, at December 31, 2016, approximately 66% of our net accounts receivable for our Hospital Operations and other segment 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. Furthermore, we may experience a short- or long-term adverse effect on our net operating revenues if we cannot replace or otherwise mitigate the impact of expired contracts with national payers. A managed care contract we had with a national payer expired on September 30, 2016; as a result, our hospitals and other healthcare facilities, as well as our employed physicians, became out-of-network providers with respect to that payer’s members. The contract represented approximately 2.9% of our net

Table of Contents

operating revenues before provision for doubtful accounts for the period subsequent to the sale of our Georgia hospitals on March 31, 2016 to the contract expiration on September 30, 2016.

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. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on competitive terms. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Any material reductions in the contracted rates we receive for our services or any significant difficulties in collecting receivables from managed care payers could have a material adverse effect on our financial condition, results of operations or cash flows. 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, including reductions in scale and scope, could have an adverse effect on our business.

For the year ended December 31, 2016, approximately 21% of our net patient revenues before provision for doubtful accounts were related to the Medicare program, and approximately 8% of our net patient revenues before provision for doubtful accounts were related to various state Medicaid programs, in each case excluding Medicare and Medicaid managed care programs. The Medicare and Medicaid programs are subject to: statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments from these government programs in the future, as well as affect the cost of providing services to our patients and the timing of payments to our facilities, which could in turn adversely affect our overall business, financial condition, results of operations or cash flows. 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 face budgetary challenges that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state’s budget, states can be expected to adopt or consider adopting future legislation designed to reduce or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted provider fee programs or have received federal government waivers allowing them to test new approaches and demonstration projects to improve care. 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.

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

Value-based purchasing and alternative payment model initiatives of both governmental and private payers tying financial incentives to quality and efficiency of care will increasingly affect the results of operations of our hospitals and other healthcare facilities, and may negatively impact our revenues if we are unable to meet expected quality standards. Medicare now requires providers to report certain quality measures in order to receive full reimbursement increases for inpatient and outpatient procedures that were previously awarded automatically. In addition,

Table of Contents

hospitals that meet or exceed certain quality performance standards will receive increased reimbursement payments, and hospitals that have "excess readmissions" for specified conditions will receive reduced reimbursement. Furthermore, Medicare no longer pays hospitals additional amounts for the treatment of certain hospital-acquired conditions ("HACs"), unless the conditions were present at admission. Beginning in FFY 2015, hospitals that rank in the worst 25% of all hospitals nationally for HACs in the previous year receive reduced Medicare reimbursements. Moreover, the ACA prohibits the use of federal funds under the Medicaid program to reimburse providers for treating certain provider preventable conditions.

The ACA also created the CMS Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries. In 2015, the Secretary of HHS announced a goal of tying 30% of traditional Medicare payments to quality or value through alternative payment models or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018. Participation in some of these models is voluntary; however, participation in certain bundled payment arrangements is mandatory for providers located in randomly selected geographic locations. Generally, the mandatory bundled payment models hold hospitals financially accountable for the quality and costs for an entire episode of care for a specific diagnosis or procedure from the date of the hospital admission or inpatient procedure through 90 days post-discharge, including services not provided by the hospital, such as physician, inpatient rehabilitation, skilled nursing and home health services. Under the mandatory models, hospitals are eligible to receive incentive payments or will be subject to payment reductions within certain corridors based on their performance against quality and spending criteria. In 2015, CMS finalized a five-year bundled payment model, called the Comprehensive Care for Joint Replacement ("CJR") model, which includes hip and knee replacements, as well as other major leg procedures. In 2016, CMS finalized additional mandatory bundled payment models, which are scheduled to begin on July 1, 2017, for Acute Myocardial Infarction ("AMI"), Coronary Artery Bypass Graft ("CABG") and Surgical Hip/Femur Fracture Treatment ("SHFFT"). Twenty of our hospitals currently participate in the CJR model and, effective July 1, 2017, certain of our hospitals are expected to be required to participate in the AMI, CABG and SHFFT models. We cannot predict what effect significant modification or repeal of the ACA as described above will have on the established payment models or the Secretary of HHS' authority to develop new payment models, nor can we predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

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

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

Our 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, as well as health insurers and private equity companies seeking to acquire providers, in specific geographic

Table of Contents

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

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

Our hospitals, outpatient centers and related healthcare businesses are subject to extensive federal, state and local regulation relating to, among other things, licensure, contractual arrangements, conduct of operations, privacy of patient information, ownership of facilities, physician relationships, addition of facilities and services, and reimbursement rates for services. The laws, rules and regulations governing the healthcare industry are extremely complex and, in certain areas, the industry has little or no regulatory or judicial interpretation for guidance. Moreover, under the ACA, the government and its contractors may suspend Medicare and Medicaid payments to providers of services “pending an investigation of a credible allegation of fraud.” The potential consequences for violating such laws, rules or regulations include reimbursement of government program payments, the assessment of civil monetary penalties, including treble damages, fines, which could be significant, exclusion from participation in federal healthcare programs, or criminal sanctions against current or former employees, any of which could have a material adverse effect on our business, financial condition or cash flows. Even a public announcement that we are being investigated for possible violations of law could have a material adverse effect on the value of our common stock and our business reputation could suffer.

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

If we fail to comply with our Non-Prosecution Agreement, we could be subject to criminal prosecution, substantial penalties and exclusion from participation in federal healthcare programs, any of which could adversely impact our

business, financial condition, results of operations or cash flows.

In September 2016, one of our subsidiaries, Tenet HealthSystem Medical, Inc., entered into a Non-Prosecution Agreement with the DOJ's Criminal Division, Fraud Section, and the U.S. Attorney's Office for the Northern District of Georgia. The NPA requires, among other things, that we and THSMI (i) fully cooperate with the Offices in any matters relating to the conduct described in the NPA and other conduct under investigation by the Offices at any time during the term of the NPA, (ii) retain an independent compliance monitor to assess, oversee and monitor our compliance with the obligations under the NPA, (iii) promptly report any evidence or allegations of actual or potential violations of the Anti-kickback Statute, (iv) maintain our compliance and ethics program throughout our operations, including those of our subsidiaries, affiliates, agents and joint ventures (to the extent that we manage or control or THSMI manages or controls such joint ventures), and (v) notify the DOJ and undertake certain other obligations specified in the NPA relative to, among other things, any sale, merger or transfer of all or substantially all of our and THSMI's respective business operations or the business operations of our or its subsidiaries or affiliates, including an obligation to include in any contract for sale, merger, transfer or other change in corporate form a provision binding the purchaser to retain the commitment of us or THSMI, or any successor-in-interest thereto, to comply with the NPA obligations except as may otherwise be agreed by the parties to the NPA in connection with a particular transaction. The powers, duties and responsibilities of the independent compliance monitor are broadly defined.

Table of Contents

The NPA is scheduled to expire on February 1, 2020 (three years from the date on which the Monitor was retained), but it may be extended or terminated early as described herein and in the NPA. If, during the term of the NPA, THSMI commits any felony under federal law, or if the Company commits any felony related to the Anti-kickback Statute, or if THSMI or the Company fails to cooperate or otherwise fails to fulfill the obligations set forth in the NPA, then THSMI, the Company and our affiliates could be subject to prosecution, exclusion from participation in federal health care programs, and other substantial costs and penalties. The Offices retain sole discretion over determining whether there has been a breach of the NPA and whether to pursue prosecution. Any liability or consequences associated with a failure to comply with the NPA could have a material adverse effect on our business, financial condition, results of operations or cash flows.

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

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

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

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

We expect to encounter increased competition from health insurers and private equity companies seeking to acquire providers in the markets where we operate physician practices and, where permitted by law, employ physicians. In some of our markets, physician recruitment and retention are affected by a shortage of physicians in certain specialties and the difficulties that physicians can experience in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance. Furthermore, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes and related regulations. All arrangements with physicians must also be fair market value and commercially reasonable. If we are unable to attract and retain sufficient numbers of quality physicians by providing adequate support personnel, technologically advanced equipment, and facilities that meet the needs of those physicians and their patients, physicians may be discouraged from referring patients to our facilities, admissions and outpatient visits may decrease and our operating performance may decline.

Table of Contents

Our USPI joint venture and our hospital-based joint ventures depend on existing relationships with key healthcare system partners. If we are not able to maintain historical relationships with these healthcare systems, or enter into new relationships, we may be unable to implement our business strategies successfully.

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

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. At December 31, 2016, approximately 23% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 34 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six expired contracts covering approximately 8% of our unionized employees and are negotiating renewals under extension agreements. We are also negotiating first contracts at three hospitals and one physician practice covering approximately 5% of our unionized employees where employees recently 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. Organizing activities by labor unions could increase our level of union representation in future periods; 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.

Table of Contents

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

If an outbreak of an infectious disease, such as the Zika virus or the Ebola virus, were to occur nationally or in one of the regions our hospitals serve, our business and financial results could be adversely 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, there can be no assurance that Conifer will be successful in generating new client relationships, including with respect to hospitals we or Conifer's other customers sell, as the respective buyers may not continue to use Conifer's services or, if they do, they may not do so under the same contractual terms. The market for Conifer's solutions is highly competitive, and we expect competition may intensify in the future. Conifer faces competition from existing participants and new entrants to the revenue cycle management market (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. In addition, electronic medical record software vendors may expand into services offerings that compete with Conifer. To be successful, Conifer must respond more quickly and effectively than its competitors to new or changing opportunities, technologies, standards, regulations and customer requirements. Moreover, existing or new competitors may introduce technologies or services that render Conifer's technologies or services obsolete or less marketable. Even if Conifer's technologies and services are more effective than the offerings of its competitors, current or potential customers might prefer competitive technologies or services to Conifer's technologies and services. Furthermore, increased competition has resulted and may continue to result in pricing pressures, which could negatively impact Conifer's margins, growth rate or market share.

The failure to comply with consumer protection laws 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 federal, state and local consumer protection laws governing such topics as privacy, finance, debt collection and credit reporting. Regulations governing debt collection are subject to changing interpretations that may be inconsistent among different jurisdictions. In addition, a regulatory determination made by, or a settlement or consent decree entered into with, one regulatory agency, such as the Consumer Financial

Protection Bureau, may not be binding upon, or preclude, investigations or regulatory actions by state or local agencies. Conifer's failure to comply with consumer financial, debt collection and credit reporting 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 statutes and regulations applicable to it could result in reduced demand for its services, invalidate all or portions of some of Conifer's services agreements with its customers, give customers the right to terminate Conifer's services agreements with them or give rise to contractual liabilities, 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 and confidential data, including

Table of Contents

protected health information, personally identifiable information, and our proprietary and confidential business performance data. We utilize electronic health records and other health information technology, along with additional technology systems, in connection with our operations, including for, among other things, billing and supply chain and labor management. Our systems, in turn, interface with and rely on third-party systems. Although we monitor and routinely test our security systems and processes and have a diversified data network that provides redundancies as well as other measures designed to protect the 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, hurricane, 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 under privacy, security, consumer protection or other applicable laws, 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.

We cannot provide any assurances that our corporate development activities will achieve their business goals or the cost and service synergies we expect.

We have completed, or have announced plans to complete, a number of acquisitions, divestitures, joint ventures and strategic alliances in recent years as part of our business strategy, and we expect to enter into similar transactions in the future. We cannot provide any assurances that these transactions will achieve their business goals or the cost and service synergies we expect. In particular, our USPI joint venture represents an increased strategic focus on ambulatory and short-stay surgical facilities, as well as related imaging services businesses, and we cannot provide any assurances that this strategy will be successful. Furthermore, with respect to acquisitions, we may not be able to identify suitable candidates, consummate transactions on terms that are favorable to us, or achieve expected returns, synergies or other benefits in a timely manner or at all. With respect to proposed divestitures of assets or businesses, we may encounter difficulties in finding acquirers or alternative exit strategies on terms that are favorable to us, which could delay the receipt of anticipated proceeds necessary for us to complete our planned strategic objectives. In

addition, our divestiture activities have required, and may in the future require, us to retain significant pre-closing liabilities, recognize impairment charges or agree to contractual restrictions that limit our ability to reenter the applicable market, which may be material.

Companies or operations acquired or joint ventures created may not be profitable or may not achieve the profitability that justifies the investments made. Furthermore, the nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our results could be adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our results could be

Table of Contents

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 IRS revenue rulings, as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit healthcare systems and related joint venture arrangements.

Our corporate development activities may present financial and operational risks, including diversion of management attention from existing core businesses and the integration or separation of personnel and financial and other systems. Future acquisitions could also result in potentially dilutive issuances of equity securities, the incurrence of additional debt, contingent liabilities and amortization expenses related to certain intangible assets, and increased operating expenses, any of which could adversely affect our results of operations and financial condition.

Our existing joint ventures may limit our flexibility with respect to such jointly owned investments and could, thereby, have a material adverse effect on our business, results of operations and financial condition, as well as our ability to sell the underlying assets or ownership interests in the joint ventures.

We have invested in a number of joint ventures with other entities when circumstances warranted the use of these structures, and we may form additional joint ventures in the future. Our participation in joint ventures is subject to the risks that:

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

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

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

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

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

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

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

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

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

Table of Contents

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

The put/call arrangements set forth in the Put/Call Agreement (as defined below) will require us to utilize our cash flow or incur additional indebtedness to satisfy the payment obligations in respect of such arrangements.

In June 2015, we entered into a Contribution and Purchase Agreement (the "Contribution and Purchase Agreement") with USPI Group Holdings, Inc. ("USPI Holdings"), Ulysses JV Holding I L.P. ("Ulysses Holding I"), Ulysses JV Holding II L.P. ("Ulysses Holding II" and, together with Ulysses Holding I, the "USPI LPs"), and the newly formed USPI Holding Company, Inc., our USPI joint venture. USPI Holdings is the parent company of United Surgical Partners International, Inc. ("USPI"). Pursuant to the terms of the Contribution and Purchase Agreement, at the closing, the USPI LPs collectively sold and contributed 100% of the equity interests of USPI Holdings to the USPI joint venture in exchange for certain shares of common stock of the USPI joint venture (the "USPI Contribution"), and we sold and contributed certain of our equity interests and other assets that comprised a portion of our ambulatory surgery center and imaging center business to the USPI joint venture (the "Tenet Contribution" and, together with the USPI Contribution, the "Contributions").We also purchased certain shares of the USPI joint venture (the "Purchase" and, together with the Contributions, the "Contribution and Purchase Transactions") from the USPI LPs such that, after giving effect to the Contribution and Purchase Transactions, we owned 50.1% and the USPI LPs, in the aggregate, owned 49.9% of the fully diluted equity interests of the USPI joint venture.

In connection with the Contribution and Purchase Agreement, we, the USPI LPs and the USPI joint venture entered into a stockholders agreement pursuant to which we and the USPI LPs agreed to certain rights and obligations with respect to the governance of the USPI joint venture. In addition, we entered into a put/call agreement (the "Put/Call Agreement") that contains put and call options with respect to the equity interests in the USPI joint venture held by the USPI LPs. Each year starting in 2016, the USPI LPs must put to us at least 12.5%, and may put up to 25%, of the USPI joint venture shares held by them immediately after the closing of the Contribution and Purchase Agreement. In each year that the USPI LPs are to deliver a put and do not put the full 25% of USPI joint venture shares allowable, we may call the difference between the number of USPI joint venture shares the USPI LPs put and the maximum number of USPI joint venture shares the USPI LPs could have put that year. In addition, the Put/Call Agreement contains certain other call options pursuant to which we will have the ability to acquire all of the ownership interests held by the USPI LPs between 2018 and 2020 (at which point we would own approximately 95% of the USPI joint venture shares). In the event of a put by the USPI LPs, we will have the ability to choose whether to settle the purchase price in cash or shares of our common stock and, in the event of a call by us, the USPI LPs will have the ability to choose whether to settle the purchase price in cash or shares of our common stock.

We have also entered into a separate put/call agreement (the "Baylor Put/Call Agreement") with Baylor that contains put and call options with respect to the equity interests in the USPI joint venture held by Baylor. Each year starting in 2021, Baylor may put up to 33.3% of their total shares in the USPI joint venture held as of January 1, 2017. In each year that Baylor does not put the full 33.3% of the USPI joint venture's shares allowable, we may call the difference between the number of shares Baylor put and the maximum number of shares they could have put that year. In addition, the Baylor Put/Call Agreement contains a call option pursuant to which we have the ability to acquire all of

Baylor's ownership interest by 2024. We have the ability to choose whether to settle the purchase price for the Baylor put/call in cash or shares of our common stock.

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

Table of Contents

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

We believe broad economic factors – including high unemployment rates in some of the markets our facilities serve 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.

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

At December 31, 2016, we had approximately $15.1 billion of total long-term debt, as well as approximately $110 million in standby letters of credit outstanding in the aggregate, under our senior secured revolving credit facility (as amended, "Credit Agreement") and our letter of credit facility agreement (as amended, "LC Facility"). Our Credit

Agreement is collateralized by patient accounts receivable of substantially all of our domestic wholly owned acute care and specialty hospitals, and our LC Facility is guaranteed and secured by a first priority pledge of the capital stock and other ownership interests of certain of our hospital subsidiaries on an equal ranking basis with our existing senior secured notes. From time to time, we expect to engage in additional capital market, bank credit and other financing activities, depending on our needs and financing alternatives available at that time.

The interest expense associated with our indebtedness offsets a substantial portion of our operating income. During 2016, our interest expense was $979 million and represented approximately 80% of our $1.22 billion of operating income. As a result, relatively small percentage changes in our operating income can result in a relatively large percentage change in our net income and earnings per share, both positively and negatively. In addition:

- Our substantial indebtedness may limit our ability to adjust to changing market conditions and place us at a competitive disadvantage compared to our competitors that have less debt.

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

Table of Contents

- Our debt service obligations reduce the amount of funds available for our operations, capital expenditures and corporate development activities, and may make it more difficult for us to satisfy our financial obligations.

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

- Some of our borrowings accrue interest at variable rates, exposing us to the risk of increased interest rates.

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

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

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

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

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

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, including those required for operating our existing hospitals, for integrating our

historical acquisitions or for future corporate development activities. We also may be forced to sell assets or operations, seek additional capital, or restructure or refinance our indebtedness. We cannot assure you that we would be able to take any of these actions, that these actions would be successful and permit us to meet our scheduled debt service obligations, or that these actions would be permitted under the terms of our existing or future debt agreements, including our Credit Agreement, LC Facility and the indentures governing our outstanding notes.

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

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

· incur, assume or guarantee additional indebtedness;

· incur liens;

· make certain investments;

Table of Contents

- provide subsidiary guarantees;

- consummate asset sales;

- redeem debt that is subordinated in right of payment to outstanding indebtedness;

- enter into sale and lease-back transactions;

- enter into transactions with affiliates; and

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

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

In addition, so long as any obligation or commitment is outstanding under our Credit Agreement and LC Facility, the terms of such facilities require us to maintain a financial ratio relating to our ability to satisfy certain fixed expenses, including interest payments. Our ability to meet these restrictive covenants and financial ratio may be affected by events beyond our control, and we cannot assure you that we will meet those tests. These restrictions could limit our ability to obtain future financing, make acquisitions or needed capital expenditures, withstand economic downturns in our business or the economy in general, conduct operations or otherwise take advantage of business opportunities that may arise. In addition, a breach of any of these covenants could cause an event of default, which, if not cured or waived, could require us to repay the indebtedness immediately. Under these conditions, we are not certain whether we would have, or be able to obtain, sufficient funds to make accelerated payments.

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

We have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our Credit Agreement, LC Facility and the indentures governing our outstanding notes. We may decide to incur additional secured or unsecured debt in the future to finance our operations and any judgments or settlements or for other business purposes.

Our Credit Agreement provides for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. Based on our eligible receivables, approximately $998 million was available for borrowing under the Credit Agreement at December 31, 2016. Our LC Facility provides for the issuance

of standby and documentary letters of credit in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). At December 31, 2016, we had no cash borrowings outstanding under the Credit Agreement, and we had approximately $110 million of standby letters of credit outstanding in the aggregate under the Credit Facility and the LC Facility. 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, 2016, we had federal net operating loss ("NOL") carryforwards of approximately $1.7 billion pretax available to offset future taxable income. These NOL carryforwards will expire in the years 2025 to 2034. Section 382 of the Internal Revenue Code imposes an annual limitation on the amount of a company's taxable income that may be offset by the NOL carryforwards if it experiences an "ownership change" as defined in Section 382 of the Code. An ownership change occurs when a company's "five-percent shareholders" (as defined in Section 382 of the Code) collectively increase their ownership in the company by more than 50 percentage points (by value) over a rolling three-year period. (This is different from a change in beneficial ownership under applicable securities laws.) These ownership changes include purchases of common stock under share repurchase programs, a company's offering of its stock, the purchase or sale of company stock by five-percent shareholders, or the issuance or exercise of rights to acquire company stock. While we expect to be able to realize our total NOL carryforwards prior to their expiration, if an ownership change occurs, our ability to use the NOL carryforwards to offset future taxable income will be subject to an

Table of Contents

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

## ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

## ITEM 2. PROPERTIES

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

## ITEM 3. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 14 to our Consolidated Financial Statements, which is incorporated by reference.

## ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

Table of Contents

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, 2016 | | |
| First Quarter | $ 30.07 | $ 21.39 |
| Second Quarter | 34.08 | 25.71 |
| Third Quarter | 31.84 | 20.93 |
| Fourth Quarter | 24.13 | 14.06 |
| | | |
| Year Ended December 31, 2015 | | |
| First Quarter | $ 52.69 | $ 41.47 |
| Second Quarter | 59.21 | 46.33 |
| Third Quarter | 60.93 | 35.76 |
| Fourth Quarter | 39.75 | 26.60 |

On February 17, 2017, the last reported sales price of our common stock on the NYSE composite tape was $19.37 per share. As of that date, there were 4,254 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 (i) the following indices (each of which was included in the stock performance graph presented in our Annual Report on Form 10-K for the year ended December 31, 2015) and a (ii) new index that we adopted in 2016. The previously disclosed indices are:

- Standard & Poor's 500 Stock Index (a broad equity market index in which we are not included);
- Standard & Poor's Health Care Composite Index (a published industry index in which we are not included); and
- A group made up of us and our hospital company peers (namely, Community Health Systems, Inc. (CYH), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS)), which we refer to as the "Old Peer Group".

In 2016, we modified the Old Peer Group to add HCA Holdings, Inc. (HCA) and LifePoint Health, Inc. (LPNT), each of which, like the other companies included in the Old Peer Group, is a publicly traded company conducting as its primary business the management of acute care hospitals. We added HCA, which became a public reporting company again in

Table of Contents

2011, to the previously disclosed peer group because a full five years of performance data for its common stock became available at December 31, 2016. We added LPNT to the peer group because we believe many investors consider LPNT to be one of our peers when evaluating our performance. We refer to the modified peer group as the "New Peer Group" and, in accordance with SEC requirements, include it with the Old Peer Group on the chart below.

Performance data assumes that $100.00 was invested on December 31, 2011 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. The stock price performance shown in the graph is not necessarily indicative of future stock price performance. The performance graph shall not be deemed "filed" for purposes of Section 18 of the Exchange Act or incorporated by reference into any of our filings under the Securities Act or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

| | 12/11 | 12/12 | 12/13 | 12/14 | 12/15 | 12/16 |
|---|---|---|---|---|---|---|
| Tenet Healthcare Corporation | $ 100.00 | $ 158.24 | $ 205.26 | $ 246.93 | $ 147.66 | $ 72.32 |
| S&P 500 | $ 100.00 | $ 116.00 | $ 153.58 | $ 174.60 | $ 177.01 | $ 198.18 |
| S&P Health Care | $ 100.00 | $ 117.89 | $ 166.76 | $ 209.02 | $ 223.42 | $ 217.41 |
| Old Peer Group | $ 100.00 | $ 147.21 | $ 213.62 | $ 283.42 | $ 225.22 | $ 159.72 |
| New Peer Group | $ 100.00 | $ 155.24 | $ 235.16 | $ 339.64 | $ 298.31 | $ 279.16 |

Table of Contents

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, 2012 through 2016. Effective June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into our new USPI joint venture. The table below includes USPI results in the 2015 column for the post-acquisition period only. 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 one-for-four reverse stock split we announced on October 1, 2012. 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, | | | | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2013 | 2012 |
| | (In Millions, Except Per-Share Amounts) | | | | |
| Net operating revenues: | | | | | |
| Net operating revenues before provision for doubtful accounts | $ 21,070 | $ 20,111 | $ 17,908 | $ 12,059 | $ 9,896 |
| Less: Provision for doubtful accounts | 1,449 | 1,477 | 1,305 | 972 | 785 |
| Net operating revenues | 19,621 | 18,634 | 16,603 | 11,087 | 9,111 |
| Equity in earnings of unconsolidated affiliates | 131 | 99 | 12 | 15 | 8 |
| Operating expenses: | | | | | |
| Salaries, wages and benefits | 9,356 | 9,011 | 8,023 | 5,371 | 4,257 |
| Supplies | 3,124 | 2,963 | 2,630 | 1,784 | 1,552 |
| Other operating expenses, net | 4,891 | 4,555 | 4,114 | 2,701 | 2,147 |
| Electronic health record incentives | (32) | (72) | (104) | (96) | (40) |
| Depreciation and amortization | 850 | 797 | 849 | 545 | 430 |
| Impairment and restructuring charges, and acquisition-related costs | 202 | 318 | 153 | 103 | 19 |
| Litigation and investigation costs, net of insurance recoveries | 293 | 291 | 25 | 31 | 5 |
| Gains on sales, consolidation and deconsolidation of facilities | (151) | (186) | — | — | — |
| Operating income | 1,219 | 1,056 | 925 | 663 | 749 |
| Interest expense | (979) | (912) | (754) | (474) | (412) |
| Loss from early extinguishment of debt | — | (1) | (24) | (348) | (4) |
| Investment earnings | 8 | 1 | — | 1 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| Income (loss) from continuing operations, before income taxes | 248 | 144 | 147 | (158) | 334 |
| Income tax benefit (expense) | (67) | (68) | (49) | 65 | (125) |
| Income (loss) from continuing operations, before discontinued operations | 181 | 76 | 98 | (93) | 209 |
| Less: Preferred stock dividends | — | — | — | — | 11 |
| Less: Net income attributable to noncontrolling interests from continuing operations | 368 | 218 | 64 | 30 | 13 |
| Net income (loss) attributable to Tenet Healthcare Corporation common shareholders from continuing operations | $ (187) | $ (142) | $ 34 | $ (123) | $ 185 |
| Basic earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations | $ (1.88) | $ (1.43) | $ 0.35 | $ (1.21) | $ 1.77 |
| Diluted earnings (loss) per share attributable to Tenet Healthcare Corporation common shareholders from continuing operations | $ (1.88) | $ (1.43) | $ 0.34 | $ (1.21) | $ 1.70 |

Table of Contents

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 timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; gains (losses) on sales, consolidation and deconsolidation of facilities; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures.

BALANCE SHEET DATA

| | December 31, | | | | |
|---|---|---|---|---|---|
| | 2016 | 2015 | 2014 | 2013 | 2012 |
| | (In Millions) | | | | |
| Working capital (current assets minus current liabilities) | $ 1,223 | $ 863 | $ 393 | $ 599 | $ 918 |
| Total assets | 24,701 | 23,682 | 17,951 | 16,450 | 9,044 |
| Long-term debt, net of current portion | 15,064 | 14,383 | 11,505 | 10,696 | 5,158 |
| Redeemable noncontrolling interests in equity of consolidated subsidiaries | 2,393 | 2,266 | 401 | 340 | 16 |
| Noncontrolling interests | 665 | 267 | 134 | 123 | 75 |
| Total equity | 1,082 | 958 | 785 | 878 | 1,218 |

CASH FLOW DATA

Years Ended December 31,

| | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|
| | (In Millions) | | | | |
| Net cash provided by operating activities | $ 558 | $ 1,026 | $ 687 | $ 589 | $ 593 |
| Net cash used in investing activities | (430) | (1,317) | (1,322) | (2,164) | (662) |
| Net cash provided by financing activities | 232 | 454 | 715 | 1,324 | 320 |

Table of Contents

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

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our Hospital Operations and other segment is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals, physician practices and health plans (certain of which are classified as held for sale as described in Note 4 to our Consolidated Financial Statements). Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI joint venture"), in which we own a majority interest, and European Surgical Partners Limited ("Aspen") facilities. At December 31, 2016, our USPI joint venture had interests in 239 ambulatory surgery centers, 34 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 27 states, and Aspen operated nine private hospitals and clinics in the United Kingdom. Our Conifer segment provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems, as well as individual hospitals, physician practices, self-insured organizations, health plans and other entities, through our Conifer Holdings, Inc. ("Conifer") subsidiary. MD&A, which should be read in conjunction with the accompanying 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, per visit and per case amounts). Continuing operations information includes the results of (i) our same 67 hospitals and six health plans operated throughout the years ended December 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) Saint Louis University Hospital ("SLUH"), which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) our two North Carolina hospitals, which we divested effective January 1, 2016, (x) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (xi) our five Georgia hospitals, which we divested effective April 1, 2016, in each case only for the period from acquisition, or

commencement of operations of the facility, as the case may be, to December 31, 2016, 2015 and 2014, as applicable. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

Welsh Carson Put Notice—In January 2017, subsidiaries of Welsh, Carson, Anderson & Stowe delivered a put notice for the minimum number of shares (representing a 6.25% ownership interest in our USPI joint venture) that they are required to put to us in 2017 according to our Put/Call Agreement, as described and defined in Note 15 to our Consolidated Financial Statements. The parties are in discussions regarding the calculation of the estimated purchase

Table of Contents

price relating to the exercise of the 2017 put option as contemplated by the Put/Call agreement. The estimated purchase price is based on an agreed-upon estimate of 2017 financial results and is subject to true-up following the finalization of actual 2017 financial results. However, we anticipate that the initial estimated payment will be between $159 million and $170 million. In addition, we are currently evaluating the additional call options available to us pursuant to the Put/Call Agreement.

## TRENDS AND STRATEGIES

The healthcare industry, in general, and the acute care hospital business, in particular, are experiencing

significant regulatory uncertainty based, in large part, on legislative efforts to significantly modify or repeal and potentially replace the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (“Affordable Care Act” or “ACA”). It is difficult to predict the full impact of these actions on our future revenues and operations. However, we believe that our ultimate success in increasing our profitability depends in part on our success in executing the strategies discussed below. In general, these strategies are intended to address the following trends shaping the demand for healthcare services: (i) consumers, employers and insurers are actively seeking lower-cost solutions and better value as they focus more on healthcare spending; (ii) patient volumes are shifting from inpatient to outpatient settings due to technological advancements and demand for care that is more convenient, affordable and accessible; (iii) the industry is migrating to value-based payment models with government and private payers shifting risk to providers; and (iv) consolidation continues across the entire healthcare sector through both traditional acquisition and divestiture activities, as well as joint ventures.

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

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

debt-to-Adjusted EBITDA.

Expansion of Our Ambulatory Care Segment—We remain focused on opportunities to expand our Ambulatory Care segment through organic growth, building new outpatient centers, corporate development activities and strategic partnerships. We believe surgery centers and surgical hospitals like those in our USPI joint venture offer many advantages to patients and physicians, including greater affordability, predictability, flexibility and convenience. Moreover, due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable in a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. In addition, we have continued to grow our imaging and urgent care businesses through our USPI joint venture's acquisitions. These acquisitions reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we offer to healthcare systems and physicians, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Historically, our outpatient services have generated significantly higher margins for us than inpatient services. We intend to increase our ownership in our USPI joint venture each year using internally generated cash with the expectation that we will own approximately 95% of the total outstanding USPI joint venture shares between 2018 and 2020.

Table of Contents

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

Improving Operating Leverage—We are focused on improving profitability by growing patient volumes and effective cost management. We believe our patient volumes have been constrained by increased competition, utilization pressure by managed care organizations, new delivery models that are designed to lower the utilization of acute care hospital services, the effects of higher patient co-pays and deductibles, depressed economic conditions in certain of our markets and demographic trends. However, we also believe that targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient services), focus on expanding our outpatient business and the implementation of new payer contracting strategies should help us grow our patient volumes. In addition, we believe our capital structure will withstand a changing interest rate environment. Approximately 94% of our long-term debt has a fixed rate of interest, and the maturity dates of our notes are staggered from 2018 through 2031. Moreover, we intend to lower our ratio of debt-to-Adjusted EBITDA, primarily through Adjusted EBITDA growth, which should lower our refinancing risk and increase the potential for us to use lower-rate secured debt to refinance portions of our higher-rate unsecured debt.

Our ability to execute on our strategies and manage the aforementioned trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of 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, 2016 and 2015 on a continuing operations basis.

Selected Operating Statistics for All Continuing Operations Hospitals— The following table shows certain selected operating statistics for our continuing operations, which includes the results of (i) our same 67 hospitals and six health plans operated throughout three months ended December 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) SLUH, which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery

Hospital, which we closed in October 2015, (ix) our two North Carolina hospitals, which we divested effective January 1, 2016, (x) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (xi) our five Georgia hospitals, which we divested effective April 1, 2016, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to December 31, 2016 and 2015, as applicable. We believe this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses.

Table of Contents

| Selected Operating Statistics | Continuing Operations Three Months Ended December 31, 2016 | 2015 | Increase (Decrease) | |
|---|---|---|---|---|
| Hospital Operations and other | | | | |
| Number of hospitals (at end of period) | 75 | 86 | (11) | (1) |
| Total admissions | 192,104 | 211,991 | (9.4) | % |
| Adjusted patient admissions(2) | 338,929 | 371,994 | (8.9) | % |
| Paying admissions (excludes charity and uninsured) | 181,617 | 200,462 | (9.4) | % |
| Charity and uninsured admissions | 10,487 | 11,529 | (9.0) | % |
| Emergency department visits | 701,100 | 778,148 | (9.9) | % |
| Total surgeries | 126,749 | 138,264 | (8.3) | % |
| Patient days — total | 888,185 | 983,856 | (9.7) | % |
| Adjusted patient days(2) | 1,543,490 | 1,710,620 | (9.8) | % |
| Average length of stay (days) | 4.62 | 4.64 | (0.4) | % |
| Average licensed beds | 20,326 | 22,549 | (9.9) | % |
| Utilization of licensed beds(3) | 47.5 % | 47.4 % | 0.1 | %(1) |
| Total visits | 1,950,549 | 2,198,005 | (11.3) | % |
| Paying visits (excludes charity and uninsured) | 1,834,844 | 2,024,725 | (9.4) | % |
| Charity and uninsured visits | 115,705 | 173,280 | (33.2) | % |
| Ambulatory Care | | | | |
| Total consolidated facilities (at end of period) | 215 | 192 | 23 | (1) |
| Total cases | 445,107 | 289,033 | 54.0 | % |

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

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

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

Total admissions decreased by 19,887, or 9.4%, in the three months ended December 31, 2016 compared to the three months ended December 31, 2015. Total surgeries decreased by 8.3% in the three months ended December 31, 2016 compared to the same period in 2015. Our emergency department visits decreased 9.9% in the three months ended December 31, 2016 compared to the same period in the prior year. Our volumes from continuing operations were negatively impacted by the decrease in our number of hospitals; however, we believe the volume decreases were partially offset by the growth we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy. Our Ambulatory Care total cases increased 54.0% due to our USPI joint venture’s acquisition of 35 urgent care centers (one of which has since been closed) effective December 31, 2015, as well as the impact associated with stepping up our USPI joint venture’s ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

| | Continuing Operations Three Months Ended December 31, | | |
|---|---|---|---|
| Revenues | 2016 | 2015 | Increase (Decrease) |
| Net operating revenues before provision for doubtful accounts | $ 5,214 | $ 5,417 | (3.7) % |
| Hospital Operations and other | | | |
| Revenues from charity and the uninsured | $ 287 | $ 267 | 7.5 % |
| Net inpatient revenues(1) | $ 2,606 | $ 2,736 | (4.8) % |
| Net outpatient revenues(1) | $ 1,457 | $ 1,616 | (9.8) % |
| Ambulatory Care revenues | $ 478 | $ 397 | 20.4 % |
| Conifer revenues | $ 402 | $ 384 | 4.7 % |

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $127 million and $96 million for the three months ended December 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $160 million and $171 million for the three months ended December 31, 2016 and 2015, respectively.

Table of Contents

Net operating revenues before provision for doubtful accounts decreased by $203 million, or 3.7%, in the three months ended December 31, 2016 compared to the same period in 2015, primarily due to lower inpatient and outpatient volumes as a result of the decrease in our number of hospitals. For our Hospital Operations and other segment, the impact of lower volumes on net operating revenues was partially mitigated by improved managed care pricing.

| | Continuing Operations Three Months Ended December 31, | | |
|---|---|---|---|
| Provision for Doubtful Accounts | 2016 | 2015 | Increase (Decrease) |
| Provision for doubtful accounts | $ 354 | $ 391 | (9.5)% |
| Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts | 6.8% | 7.2% | (0.4)(1) |

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

Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 6.8% and 7.2% for the three months ended December 31, 2016 and 2015, respectively. This improvement was primarily due to the growth in our Ambulatory Care segment, where bad debt expense is a much smaller percentage of revenues relative to our hospitals. Our accounts receivable days outstanding ("AR Days") from continuing operations were 54.8 days at December 31, 2016 and 49.5 days at December 31, 2015, within our target of less than 55 days.

| | Continuing Operations Three Months Ended December 31, | | |
|---|---|---|---|
| Selected Operating Expenses | 2016 | 2015 | Increase (Decrease) |
| Hospital Operations and other | | | |
| Salaries, wages and benefits | $ 1,925 | $ 2,075 | (7.2)% |
| Supplies | 674 | 738 | (8.7)% |
| Other operating expenses | 1,034 | 1,067 | (3.1)% |
| Total | $ 3,633 | $ 3,880 | (6.4)% |
| Ambulatory Care | | | |
| Salaries, wages and benefits | $ 157 | $ 130 | 20.8% |
| Supplies | 99 | 79 | 25.3% |
| Other operating expenses | 83 | 78 | 6.4% |
| Total | $ 339 | $ 287 | 18.1% |
| Conifer | | | |
| Salaries, wages and benefits | $ 242 | $ 238 | 1.7% |
| Other operating expenses | 88 | 85 | 3.5% |
| Total | $ 330 | $ 323 | 2.2% |
| Total | | | |
| Salaries, wages and benefits | $ 2,324 | $ 2,443 | (4.9)% |

| | | | | |
|---|---|---|---|---|
| Supplies | 773 | 817 | (5.4) | % |
| Other operating expenses | 1,205 | 1,230 | (2.0) | % |
| Total | $ 4,302 | $ 4,490 | (4.2) | % |
| Rent/lease expense(1) | | | | |
| Hospital Operations and other | $ 62 | $ 67 | (7.5) | % |
| Ambulatory Care | 19 | 15 | 26.7 | % |
| Conifer | 4 | 4 | — | % |
| Total | $ 85 | $ 86 | (1.2) | % |

(1) Included in other operating expenses.

Table of Contents

| Selected Operating Expenses per Adjusted Patient Admission | Continuing Operations Three Months Ended December 31, 2016 | 2015 | Increase (Decrease) |
|---|---|---|---|
| Hospital Operations and other | | | |
| Salaries, wages and benefits per adjusted patient admission(1) | $ 5,680 | $ 5,577 | 1.8 % |
| Supplies per adjusted patient admission(1) | 1,989 | 1,984 | 0.3 % |
| Other operating expenses per adjusted patient admission(1) | 3,074 | 2,890 | 6.4 % |
| Total per adjusted patient admission | $ 10,743 | $ 10,451 | 2.8 % |

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

Salaries, wages and benefits per adjusted patient admission increased 1.8% in the three months ended December 31, 2016 compared to the same period in 2015. This change is primarily due to annual merit increases for certain of our employees and the effect of lower volumes on operating leverage due to the sale of certain of our hospitals since the 2015 period, partially offset by decreased accruals for annual incentive compensation, in the three months ended December 31, 2016 compared to the three months ended December 31, 2015.

Supplies expense per adjusted patient admission increased 0.3% in the three months ended December 31, 2016 compared to the three months ended December 31, 2015. The change in supplies expense was primarily attributable to growth in our higher acuity supply-intensive surgical services, partially offset by the impact of the group-purchasing strategies and supplies-management services we utilize to reduce costs.

Other operating expenses per adjusted patient admission increased by 6.4% in the three months ended December 31, 2016 compared to the three months ended December 31, 2015. This increase is due to higher contracted services and medical fees, the effect of lower volumes on operating leverage due to the sale of certain of our hospitals since the 2015 period, and increased costs associated with our health plans due to an increase in covered lives, which costs were partially offset by increased health plan revenues. Malpractice expense for our Hospital Operations and other segment was $33 million lower in the 2016 period compared to the 2015 period. The 2016 period included a favorable adjustment of approximately $19 million due to an 83 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $7 million as a result of a 34 basis point increase in the interest rate in the 2015 period.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $716 million at December 31, 2016 compared to $649 million at September 30, 2016.

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

- Net cash provided by operating activities before interest, taxes and restructuring charges, acquisition-related costs, and litigation costs and settlements of $613 million;

- Payments for restructuring charges, acquisition-related costs and litigation costs and settlements of $559 million, which payments include approximately $517 million related to our Clinica de la Mama matter, which is described in Note 14 to our Consolidated Financial Statements;

- Capital expenditures of $261 million;

- Purchases of businesses or joint venture interests of $21 million;

- Interest payments of $336 million;

- $750 million proceeds from the issuance of our 7$1/_2$% senior secured notes due 2022; and

Table of Contents

- $67 million of distributions paid to our noncontrolling interests.

Net cash provided by operating activities was $558 million in the year ended December 31, 2016 compared to $1.026 billion in the year ended December 31, 2015. Key positive and negative factors contributing to the change between the 2016 and 2015 periods include the following:

- Increased income from continuing operations before income taxes of $137 million, excluding investment earnings (losses), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the year ended December 31, 2016 compared to the year ended December 31, 2015;

- An increase of $491 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements;

- Approximately $84 million of additional net cash proceeds in the 2016 period related to supplemental Medicaid programs in California and Texas;

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

- Higher interest payments of $73 million.

- A $15 million decrease in cash used in discontinued operations; and

- The timing of other working capital items.

SOURCES OF REVENUE

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

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

| | Years Ended December 31, | | |
|---|---|---|---|
| Net Patient Revenues from: | 2016 | 2015 | 2014 |
| Medicare | 20.5% | 20.4 % | 22.0% |
| Medicaid | 8.2 % | 8.7 % | 9.6 % |
| Managed care | 61.5% | 60.6 % | 58.4% |
| Indemnity, self-pay and other | 9.8 % | 10.3 % | 10.0% |

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

| | Years Ended December 31, | | |
|---|---|---|---|
| Admissions from: | 2016 | 2015 | 2014 |
| Medicare | 26.1% | 26.7% | 27.5% |
| Medicaid | 7.0 % | 8.0 % | 10.3% |
| Managed care | 59.2% | 57.5% | 54.5% |
| Indemnity, self-pay and other | 7.7 % | 7.8 % | 7.7 % |

Table of Contents

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services ("HHS"), is the single largest payer of healthcare services in the United States. Approximately 55 million individuals rely on healthcare benefits through Medicare, and approximately 74 million individuals are enrolled in Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and directed by CMS. Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

The Affordable Care Act

Several provisions of the ACA, including premium assistance and cost sharing subsidies for insurance products purchased through the health insurance exchanges, and the expansion of Medicaid in the 31 states (including six in which we operate acute hospitals) and the District of Columbia that have taken action to do so, are financed through:

- negative adjustments to the annual market basket updates for Medicare hospital inpatient, outpatient, prospective payment systems, which began in 2010, as well as additional negative "productivity adjustments" to the annual market basket updates which began in 2011; and

- reductions to Medicare and Medicaid disproportionate share hospital ("DSH") payments, which began for Medicare payments in federal fiscal year ("FFY") 2014 and will begin for Medicaid payments in FFY 2018.

We cannot predict if or when modification or repeal of the ACA will take effect or what action, if any, Congress might take with respect to replacing the law. We are also unable to predict the impact of legislative and regulatory changes on our future revenues and operations. However, if the ultimate impact is that significantly fewer individuals have private or public health coverage, we will experience decreased volumes, reduced revenues, an increase in uncompensated care and a higher level of bad debt expense, which would adversely affect our results of operations and cash flows. This negative effect will be exacerbated if the ACA's reductions in the growth of Medicare spending and reductions in Medicare DSH payments that have already taken effect are not reversed if the law is repealed or if further reductions (including Medicaid DSH reductions previously scheduled to take effect under the ACA in FFY 2018) are made.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes “Part A” and “Part B”), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called “Part C” or “MA Plans”), includes health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues from continuing operations of our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the years ended December 31, 2016, 2015 and 2014 are set forth in the following table:

Table of Contents

| | Years Ended December 31, | | |
|---|---|---|---|
| Revenue Descriptions | 2016 | 2015 | 2014 |
| Medicare severity-adjusted diagnosis-related group — operating | $ 1,705 | $ 1,744 | $ 1,677 |
| Medicare severity-adjusted diagnosis-related group — capital | 157 | 161 | 154 |
| Outliers | 77 | 61 | 69 |
| Outpatient | 927 | 953 | 896 |
| Disproportionate share | 293 | 337 | 370 |
| Direct Graduate and Indirect Medical Education(1) | 249 | 256 | 250 |
| Other(2) | 63 | 5 | 98 |
| Adjustments for prior-year cost reports and related valuation allowances | 55 | 62 | 30 |
| Total Medicare net patient revenues | $ 3,526 | $ 3,579 | $ 3,544 |

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

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

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

Acute Care Hospital Inpatient Prospective Payment System

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

The base payment amount for the operating component of the MS-DRG payment is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. Both the labor-related share of operating base payments and the base payment amount for capital costs are adjusted for geographic variations in labor and capital costs, respectively. Using diagnosis and procedure information submitted by the hospital, CMS assigns to each discharge an MS-DRG, and the base payments are multiplied by the relative weight of the MS-DRG

assigned. The MS DRG operating and capital base rates, relative weights and geographic adjustment factors are updated annually, with consideration given to: the increased cost of goods and services purchased by hospitals; the relative costs associated with each MS-DRG; and changes in labor data by geographic area. Although these payments are adjusted for area labor and capital cost differentials, the adjustments do not take into consideration an individual hospital's operating and capital costs.

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

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

Table of Contents

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 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. Generally, the factors used to calculate and distribute the UC DSH pool are set forth in the ACA and are not subject to administrative or judicial review. The annual estimate of the size of the UC DSH pool is made by the CMS Office of the Actuary and is based on the projections of total DSH payments that would have been made under the pre-ACA formula. Although the statute requires that each hospital's cost of uncompensated care as a percentage of the total uncompensated care cost of all DSH hospitals be used to allocate the pool, CMS determined that the available cost data from cost reports was unreliable and is using low income days (i.e., Medicaid days) to distribute the pool. For FFY 2017, CMS is using low income days to allocate the UC DSH pool. In the FFY 2017 IPPS Final Rule, CMS stated that: (1) it expected uncompensated care cost data would be available for distribution of the UC DSH pool no later than FFY 2021, and (2) it would explore whether there is an appropriate proxy for uncompensated care cost that could be used to allocate the UC DSH pool until the agency determines that the data from the cost reports can be used for that purpose. We cannot predict what action, if any, CMS will take, the timing of such action, or what impact such action will have on our net revenues and cash flows.

During 2016, 66 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 of Medicare inpatient days attributable to patients receiving Supplemental Security Income ("SSI") who are also eligible for Medicare Part A benefits divided by total Medicare inpatient days (the "SSI Ratio"). In an earlier rulemaking, CMS established a policy of including not only days attributable to Original Medicare Plan patients, but also Medicare Advantage patients in the SSI ratio. The statutes and regulations that govern Medicare DSH payments have been the subject of various administrative appeals and lawsuits, and our hospitals have been participating in such appeals, including challenges to the inclusion of the Medicare Advantage days used in the DSH calculation as set forth in the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates ("FFY 2005 Final Rule"). 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 2016, 26 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 (“APCs”). Services in each APC are similar clinically and in terms of the resources they require, and a payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. CMS annually updates the APCs and the rates paid for each APC.

Inpatient Psychiatric Facility Prospective Payment System

The inpatient psychiatric facility 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

Table of Contents

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. During 2016, 27 of our general hospitals operated IPF units.

Inpatient Rehabilitation Prospective Payment System

Rehabilitation hospitals and rehabilitation units in acute care hospitals meeting certain criteria established by CMS are eligible to be paid as an inpatient rehabilitation facility (“IRF”) under the IRF prospective payment system (“IRF-PPS”). Payments under the IRF-PPS are made on a per-discharge basis. The IRF-PPS uses federal prospective payment rates across distinct case-mix groups established by a patient classification system. During 2016, we operated one freestanding IRF, and 21 of our general hospitals operated IRF units.

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. Beginning in CY 2017, the payments for physician services will be based on the provisions prescribed by The Medicare Access and Children’s Health Insurance Program Act (“MACRA”) that was signed into law on April 16, 2015 as described below.

Cost Reports

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

For filed cost reports, we adjust the accrual for estimated cost report settlements based on those cost reports and subsequent activity, and record a valuation allowance against those cost reports based on historical settlement trends. The accrual for estimated cost report settlements for periods for which a cost report is yet to be filed is recorded based on estimates of what we expect to report on the filed cost reports and a corresponding valuation allowance is recorded

as previously described. Cost reports must generally be filed within five months after the end of the annual cost report reporting period. After the cost report is filed, the accrual and corresponding valuation allowance may need to be adjusted.

Medicare Claims Reviews

HHS estimates that approximately 11% of all Medicare Fee-For-Service (“FFS”) claim payments in FFY 2016 were improper. CMS has identified the FFS program as a program at risk for significant erroneous payments. One of CMS’ stated key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. According to CMS, paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of Medicare Trust Fund dollars. CMS has established several initiatives to prevent or identify improper payments before a claim is paid, and to identify and recover improper payments after paying a claim. The overall goal is to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types. Under the authority of the Act, CMS employs a variety of contractors (e.g., Medicare Administrative Contractors and Recovery Audit Contractors) to process and review claims according to Medicare rules and regulations.

Claims selected for prepayment review are not subject to the normal Medicare FFS payment timeframe. Furthermore, prepayment and post payment claims denials are subject to administrative and judicial review, and we intend to pursue the reversal of adverse determinations where appropriate. We have established robust protocols to

Table of Contents

respond to claims reviews and payment denials. In addition to overpayments that are not reversed on appeal, we will incur additional costs to respond to requests for records and pursue the reversal of payment denials. The degree to which our Medicare FFS claims are subjected to prepayment reviews, the extent to which payments are denied, and our success in overturning denials could have a material adverse effect on our cash flows and results of operations.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 17.2%, 18.3% and 18.1% of total net patient revenues before provision for doubtful accounts for the years ended December 31, 2016, 2015 and 2014, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the years ended December 31, 2016, 2015 and 2014, our total Medicaid supplemental revenues attributable to DSH and other supplemental revenues were approximately $906 million, $888 million and $817 million, respectively. The $906 million of total Medicaid supplemental revenues attributable to DSH and other supplemental revenues for the year ended December 31, 2016 was comprised of $232 million related to the California Provider Fee program, $228 million related the Michigan Provider Fee program, $176 million related to Medicaid DSH programs in multiple states, $142 million related to the Texas 1115 waiver program, and $128 million from a number of other state and local based programs.

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

The California Department of Health Care Services (DHCS) implemented its first Hospital Quality Assurance Fee (“HQAF”) program in 2010. The HQAF program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The fourth and most recent phase of the program (“HQAF IV”) covering the period January 2014 through December 2016 was authorized by legislation enacted in October 2013 and approved by CMS in the three months ended December 31, 2014. Under this program, our hospitals recognized revenues, net of provider fees and other expenses, of approximately $232 million, $188 million and $165 million in calendar years 2016, 2015 and 2014, respectively. In November 2016, California voters approved a state constitutional amendment measure that extends indefinitely the statute that imposes fees on hospitals to obtain federal matching funds. However,

the current program expired on December 31, 2016 and CMS has not approved a new program. Consistent with the first four phases of the HQAF program, net revenue associated with HQAF V will not be recognized until CMS issues the required approvals. Because the HQAF supplemental payments are partially funded by the federal government, each phase of the program must be approved by CMS, and the approval process can be lengthy. With the expiration of the HQAF IV program on December 31, 2016, we anticipate that: (1) during the three months ending March 31, 2017 the state will submit to CMS a request for approval of a 30-month program covering the period January 2017 through June 2019 ("HQAF V"); and (2) CMS approval of the HQAF V may occur as early as late 2017, although we cannot provide any assurances in regard to either. Because HQAF funding levels are based in part on Medi-Cal utilization, changes in coverage of individuals under the Medi-Cal program could affect the net revenues and cash flows of our hospitals under HQAF V and subsequent phases of the HQAF program. Accordingly, we are unable to predict the amount of net revenues our hospitals may receive from or the timing of CMS' approval of the HQAF V program.

Certain of our Texas hospitals participate in the Texas 1115 waiver program. The current waiver term expires on December 31, 2017, is funded by intergovernmental transfer payments from local government entities, and includes two funding pools – Uncompensated Care and Delivery System Reform Payment. In 2016, we recognized $142 million

Table of Contents

of revenues from the Texas 1115 waiver program. Separately, during the same period, we incurred $79 million of expenses related to funding indigent care services by certain of our Texas hospitals. On September 30, 2016, the State of Texas submitted a request to CMS to extend the 1115 waiver program for a period of five years. We cannot provide any assurances as to the extension of the 1115 waiver program, or the ultimate amount of revenues that our hospitals may receive from this program in 2017 or future periods.

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

Medicaid-related patient revenues from continuing operations recognized by our Hospital Operations and other segment from Medicaid-related programs in the states in which our hospitals are located, as well as from Medicaid programs in neighboring states, for the years ended December 31, 2016, 2015 and 2014 are set forth in the table below:

| | Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2016 | | 2015 | | 2014 | |
| Hospital Location | Medicaid | Managed Medicaid | Medicaid | Managed Medicaid | Medicaid | Managed Medicaid |
| California | $ 401 | $ 417 | $ 343 | $ 401 | $ 311 | $ 257 |
| Michigan | 349 | 314 | 366 | 306 | 337 | 270 |
| Texas | 235 | 231 | 264 | 237 | 280 | 223 |
| Florida | 95 | 166 | 97 | 162 | 158 | 103 |
| Alabama | 80 | — | 37 | — | 12 | — |
| Pennsylvania | 80 | 199 | 66 | 206 | 73 | 194 |
| Illinois | 37 | 69 | 88 | 50 | 80 | 32 |
| Massachusetts | 37 | 52 | 37 | 50 | 39 | 46 |
| South Carolina | 16 | 34 | 16 | 33 | 18 | 34 |
| Georgia | 11 | 8 | 69 | 39 | 73 | 36 |
| Tennessee | 5 | 34 | 6 | 32 | 7 | 29 |
| Missouri | 2 | — | 50 | 14 | 67 | 9 |
| Arizona | — | 199 | (16) | 195 | 1 | 113 |
| North Carolina | (2) | — | 28 | 6 | 26 | 5 |
| | $ 1,346 | $ 1,723 | $ 1,451 | $ 1,731 | $ 1,482 | $ 1,351 |

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.

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

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year ("FFY"). On August 2, 2016, CMS issued Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2017 Rates. On September 30, 2016, CMS issued a notice that corrects technical and typographical errors in the August 2, 2016 rule. The August 2, 2016 final rule and the September 30, 2016 correction

Table of Contents

notice are hereinafter referred to as the "Final IPPS Rule". The Final IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.7% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record ("EHR") technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS is also making certain adjustments to the 2.7% market basket increase that result in a net operating payment update to the operating standardized amount of 0.95% (before budget neutrality adjustments), including:

- Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.3%, respectively;

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

- Prospective reversal of the 0.2% reduction related to the two-midnight rule that was first imposed in FFY 2014; and

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

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

- A 1.84% net increase in the capital federal MS-DRG rate; and

- An increase in the cost outlier threshold from $22,544 to $23,573.

CMS projects that the combined impact of the payment and policy changes in the Final IPPS Rule will yield an average 0.9% increase in operating MS-DRG payments for hospitals in large urban areas (populations over one million) in FFY 2017. The final payment and policy changes affecting operating MS-DRG payments and other rules, including those affecting Medicare UC-DSH payments, result in an estimated 0.5% increase in our annual IPPS payments, which yields an estimated increase of approximately $11 million in our annual Medicare IPPS payments. Because of the uncertainty regarding factors that may influence our future IPPS payments by individual hospital, including legislative action, admission volumes, length of stay and case mix, we cannot provide any assurances regarding our estimate of the impact of the payment and policy changes.

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

On November 1, 2016, CMS released the final policy changes, quality provisions and payment rates for the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for calendar year 2017 ("Final OPPS/ASC Rule"). The Final OPPS/ASC rule includes the following changes:

· An net increase in the OPPS rates of 1.65% based on an estimated market basket increase of 2.7% reduced by market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.3%, respectively;

· Policies to implement Section 603 of the Bipartisan Budget Act of 2015, which requires that certain items and services furnished by certain off-campus hospital departments shall not be considered covered outpatient department services for purposes of OPPS payments and shall instead be paid "under the applicable payment system" which, beginning January 1, 2017, is approximately 50% of the OPPS rate;

Table of Contents

- The removal of five spine procedure codes and two laryngoplasty codes from the CMS list of procedures that can be performed only on an inpatient basis (the "Inpatient Only List");

- A 1.9% update to the ASC payment rates; and

- Reducing the Electronic Health Record reporting period for 2016 and 2017 from 12 months to a consecutive 90-day period.

CMS projects that the combined impact of the payment and policy changes in the Final OPPS/ASC Rule will yield an average 1.7% increase in OPPS payments for all facilities and an average 1.7% increase in OPPS payments for hospitals in large urban areas (populations over one million). Based on CMS' estimates, the projected annual impact of the payment and policy changes in the Final OPPS/ASC Rule on our hospitals is an increase to Medicare outpatient revenues of approximately $15 million. Because of the uncertainty associated with various factors that may influence our future OPPS payments, including legislative action, volumes and case mix, we cannot provide any assurances regarding our estimate of the impact of the changes.

The Medicare Access and CHIP Reauthorization Act of 2015

The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") replaces the Medicare Sustainable Growth Rate methodology with a new system for establishing the annual updates to payment rates for physician services in Medicare that, beginning in 2019, rewards the delivery of high-quality patient care through one of two avenues:

- The Merit-Based Incentive Payment System ("MIPS") – MIPS-participating providers will be eligible for a payment adjustment of plus or minus 4% in the first payment adjustment year (2019 based on 2017 performance) with the payment adjustment increasing each year until it reaches plus or minus 9% in 2022 and beyond; or

- The Advanced Alternative Payment Model ("APM") – Providers that choose to participate in an Advanced APM (defined as certain CMS Innovation Center models and Shared Savings Program tracks that require participants to use certified EHR technology, base payments for services on quality measures comparable to those in MIPS, and require participants to bear more than nominal financial risk for losses) will be exempt from MIPS and from 2019-2024 will be eligible for a 5% upward adjustment to their Medicare payments.

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

Additionally, the MACRA reduces the restoration of the 3.2% coding and document adjustment to hospital inpatient rates that was expected to be effective in FFY 2018. Under the legislation, the reduced amount is 3.0% and will be

applied at the rate of 0.5% over six years beginning in FFY 2018. This provision was subsequently modified by the 21st Century Cures Act of 2016 as described below.

On October 14, 2016, CMS issued a final rule implementing MACRA. In the final rule, CMS made several changes to the proposed rule including:

· Reducing the MIPS reporting burden in the first performance year (2017). Per the final rule, providers may begin reporting under MIPS at any time between January 1, 2017 and October 2, 2017 and can avoid a payment penalty in 2019 by reporting as little as one quality measure or one improvement activity. CMS also reduced the thresholds by which a provider in a small practice must participate.

· Changes to the APMs (including the Comprehensive Care and Joint Replacement (“CJR”) model) that will be eligible as Advanced APMs for bonus payment purposes.

Table of Contents

Less than 1% of the net operating revenue generated by our Hospital Operations and other segment during the year ended December 31, 2016 was related to the Medicare fee-for-service Physician Fee Schedule. We are unable to estimate the potential impact of MACRA; however, the maximum incentive and penalty adjustments could result in an increase or decrease in our annual net revenues of approximately $15 million. Additionally, we cannot predict the effect of MACRA on our future operations, revenues and cash flows.

Payment and Policy Changes to the Medicare Physician Fee Schedule

On November 2, 2016, CMS issued a final rule updating the MPFS for calendar year 2017 (“MPFS Final Rule”). This final rule updates payment policies, payment rates, and other provisions for services furnished under the MPFS on or after January 1, 2017. In addition to policies affecting the calculation of payment rates, the final rule identifies potentially misvalued codes, adds procedures to the telehealth list, and finalizes a number of new policies, including several that are a result of recently enacted legislation. As a result of the final rule, the MPFS conversion factor for 2017 will increase by 0.24%. CMS estimates that the impact of the payment and policy changes in the final rule will result in no change in aggregate payments across all specialties.

Bipartisan Budget Act of 2015

On November 2, 2015, the President signed the Bipartisan Budget Act of 2015 (“BBA 2015”). The legislation raises the debt ceiling through March 2017 and establishes a federal budget through FFY 2017. The BBA 2015 includes the following payment policies affecting Medicare beneficiaries, hospitals and other providers:

· Medicare Part B premium relief for the 30% of beneficiaries facing massive increases beginning in 2016;

· An extension through FFY 2025 of a 2% reduction (referred to as the “sequestration adjustment”) to all Medicare payments, mandated by the Budget Control Act of 2011, that was originally scheduled to expire in 2021 and subsequently extended through 2024; and

· Creation of a site-neutral payment policy for services provided in off-campus outpatient departments of hospitals. This provision:

· Creates a permanent exemption from site-neutral payment adjustments for off-campus hospital-based emergency departments;

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Grandfathers off-campus hospital outpatient departments that billed for services under the OPPS as of the date of enactment; and

· Provides that, beginning January 1, 2017, off-campus hospital outpatient departments that are not grandfathered or exempt will be paid under the MPFS or ASC fee schedule (this measure was amended by the 21st Century Cures Act as described below).

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 funded by the federal government and administered by the states, are subject to separate payment policies.

During the year ended December 31, 2016, we recognized approximately $32 million of EHR incentives related to the Medicare and Medicaid EHR incentive programs as a result of certain of our hospitals, employed physicians and Ambulatory Care segment facilities demonstrating meaningful use of certified EHR technology and meeting the criteria for revenue recognition. The final Medicare EHR hospital 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.

Table of Contents

We anticipate recognizing approximately $9 million of Medicare and Medicaid EHR incentive payments in 2017. 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 approximately $34 million in 2017 and subsequent years.

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 facilities and physicians 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, our ability to achieve compliance and the associated costs, we cannot provide any assurances regarding the aforementioned estimates of incentives or penalties in future periods.

21st Century Cures Act

On December 13, 2016, the President signed the 21st Century Cures Act ("Cures Act") legislation intended to accelerate the "discovery, development and delivery" of medical therapies by encouraging biomedical research investment and facilitating innovation review and approval processes, and several other health-related measures, including changes affecting Medicare payments to hospitals and other providers, including:

- Relief for certain off-campus hospital-based sites that were under development from the provisions of section 603 of the Bipartisan Budget Act of 2015;

- Requiring CMS to develop Healthcare Common Procedure Coding System ("HCPCS") codes (used to code outpatient services) associated with 10 surgical MS-DRGs that commonly have a one-day length of stay to translate outpatient surgical codes into inpatient surgical MS-DRGs as one of the steps to help develop a unified hospital payment system; and

- Reducing the coding and documentation adjustment to inpatient hospital payment rates under the MACRA from an increase of 0.5 percentage points to an increase of 0.4588 percentage points in 2018.

CMS Innovation Models

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of Section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS. The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for communities and lower costs through improvement for our health care system. Generally, the models include ACOs and Episodic Bundled Payment Model ("EPM") initiatives. Participation in these programs is either voluntary or mandatory. For example, participation in the Shared Savings ACO is voluntary; whereas participation in certain bundled payment models is mandatory.

On December 20, 2016, CMS finalized new Innovation Center models that continue the progress toward shifting Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for healthcare providers to deliver better care to patients at a lower cost. These models are intended to avoid complications, prevent hospital readmissions, and speed recovery. In December 2016, CMS released a final rule, the Advancing Care Coordination Through Episode Payment Models ("EPMs") rule. This rule:

Table of Contents

- makes changes to the current CJR demonstration to conform to the other EPMs;

- implements testing of three EPMs that address care of:
  - acute myocardial infarction ("AMI"),
  - coronary artery bypass graft ("CABG"), and
  - surgical hip/femur fracture treatment ("SHFFT").

- establishes the Cardiac Rehabilitation Incentive Payment Model ("CR"), designed to complement the AMI and CABG EPMs.

Participants for all four models (AMI, CABG, SHFFT, and CR) are IPPS acute care hospitals in selected geographic areas and participation is mandatory. Similar to the CJR, under the three new EPMs, inpatient and 90-day post-discharge payments will be retrospectively bundled, and quality-adjusted comparison of actual to target expenditures for each EPM hospital will result in reconciliation payments (from CMS to participants) or repayments (from participants to CMS). The first performance year for the new EPMs is scheduled to begin on July 1, 2017, and the demonstrations expire on December 31, 2021.

Currently, 20 of our acute care hospitals participate in the CJR and are expected to be required to participate in the SHFFT EPM, 12 of our acute care hospitals are expected to be required to participate in the AMI and CABG demonstrations, and 16 of our hospitals are expected to participate in the CR program. We cannot predict what impact, if any, these demonstration programs will have on our inpatient volumes, net revenues or cash flows.

Medicaid Managed Care Final Rule – Pass Through Payments

In a final rule issued in 2016, CMS stated that managed care regulations prohibit states from making payments to providers for services available under a contract between the state and the managed care plan, and the agency interprets those regulations to also prohibit states from making supplemental payments to providers (referred to as "pass-through" payments) through a managed care plan. In that rule, CMS: (1) stated its belief that pass-through payments are not actuarially sound because they do not tie provider payments to the provision of services and limited the managed care plans' ability to effectively manage care delivery, and (2) that it would allow states, managed care plans and providers 10 years to phase out pass-through payments. On January 17, 2017, CMS issued a Final Medicaid Managed Care rule that clarified and established additional policies regarding Medicaid managed care pass-through payments that will affect how Medicaid managed care supplemental payments are distributed to providers. Specifically,

- States may not create new pass-through payment programs;

- Pass-through payments that will be permitted through the phase down period will be limited to the rates that states had submitted to CMS as of July 5, 2016; and

- Although the change in CMS' policy results in a reduction of the pass-through payments over a 10-year period, states may instead implement new "Permissible Directed Payments" in Medicaid managed care programs, which could include uniform dollar or percentage increases in rates, minimum or maximum fee schedules.

In the January 17, 2017 final rule, CMS estimates that at least 16 states have implemented pass-through payments for hospitals, although the individual states are not identified. Some states in which we operate hospitals have established supplemental payment programs which include payments that may possibly meet CMS' definition of pass-through payments, and would, therefore, be subject to the provisions of the Medicaid Managed Care final rule. Although CMS' policy requires the gradual phase out of pass-through payments, the agency concluded that, because states have other mechanisms to build in amounts currently provided through pass-through payments in approvable ways, the fiscal impact in aggregate spending would not be significant. However, transitioning from pass-through payments to other payment structures could result in a redistribution of payments among providers. We are unable to predict what actions the states affected by the rule will take with respect to CMS' policy, including the development of permissible

Table of Contents

alternative managed care payment structures to offset the phase out of pass-through payments over the transition period, or what impact those actions might have on our operations, 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, 2016, 2015 and 2014 was $11.2 billion, $10.6 billion and $9.3 billion, respectively. Approximately 61% of our managed care net patient revenues for the year ended December 31, 2016 was derived from our top ten managed care payers. National payers generated approximately 44% of our total net managed care revenues. The remainder comes from regional or local payers. At December 31, 2016 and 2015 approximately 66% and 63%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

A managed care contract we had with a national payer expired on September 30, 2016; as a result, our hospitals and other healthcare facilities, as well as our employed physicians, became out-of-network providers with respect to that payer’s members. The contract represented approximately 2.9% of our net operating revenues before provision for doubtful accounts for the period subsequent to the sale of our Georgia hospitals on March 31, 2016 to the contract expiration on September 30, 2016. Although there can be no assurance that we will enter into negotiations or reach an agreement with the payer on a new contract, we do not anticipate the expiration of the contract to have a long-term material adverse impact on our business, financial condition or results of operations.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at December 31, 2016, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we

Table of Contents

believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefitted from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate recently, and we believe the moderation could continue in future years. In the year ended December 31, 2016, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 77% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

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

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant number of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts.

Self-pay accounts pose significant collectability problems. At December 31, 2016 and 2015, approximately 4% and 5%, respectively, of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which is subject to various statutes and regulations regarding consumer protection in areas including finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, of Part I of this report.

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

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

Table of Contents

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) of caring for self-pay patients and charity care patients, as well as revenues attributable to DSH and other supplemental revenues we recognized, in the years ended December 31, 2016, 2015 and 2014.

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Estimated costs for: | | | |
| Self-pay patients | $ 644 | $ 678 | $ 620 |
| Charity care patients | $ 146 | $ 191 | $ 180 |
| Medicaid DSH and other supplemental revenues | $ 906 | $ 888 | $ 817 |

The expansion of health insurance coverage has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage and for persons living in the country who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

## RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2016 COMPARED TO THE YEAR ENDED DECEMBER 31, 2015

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the years ended December 31, 2016 and 2015:

| Years Ended December 31, | | |
|---|---|---|
| | | Increase |
| 2016 | 2015 | (Decrease) |

| | | | |
|---|---|---|---|
| Net operating revenues: | | | |
| General hospitals | $ 16,488 | $ 16,741 | $ (253) |
| Other operations | 4,582 | 3,370 | 1,212 |
| Net operating revenues before provision for doubtful accounts | 21,070 | 20,111 | 959 |
| Less provision for doubtful accounts | 1,449 | 1,477 | (28) |
| Net operating revenues | 19,621 | 18,634 | 987 |
| Equity in earnings of unconsolidated affiliates | 131 | 99 | 32 |
| Operating expenses: | | | |
| Salaries, wages and benefits | 9,356 | 9,011 | 345 |
| Supplies | 3,124 | 2,963 | 161 |
| Other operating expenses, net | 4,891 | 4,555 | 336 |
| Electronic health record incentives | (32) | (72) | 40 |
| Depreciation and amortization | 850 | 797 | 53 |
| Impairment and restructuring charges, and acquisition-related costs | 202 | 318 | (116) |
| Litigation and investigation costs | 293 | 291 | 2 |
| Gains on sales, consolidation and deconsolidation of facilities | (151) | (186) | 35 |
| Operating income | $ 1,219 | $ 1,056 | $ 163 |

Table of Contents

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | Increase (Decrease) |
| Net operating revenues | 100.0% | 100.0% | — % |
| Equity in earnings of unconsolidated affiliates | 0.7 % | 0.5 % | 0.2 % |
| Operating expenses: | | | |
| Salaries, wages and benefits | 47.7 % | 48.4 % | (0.7) % |
| Supplies | 15.9 % | 15.9 % | — % |
| Other operating expenses, net | 25.0 % | 24.4 % | 0.6 % |
| Electronic health record incentives | (0.2) % | (0.4) % | 0.2 % |
| Depreciation and amortization | 4.3 % | 4.3 % | — % |
| Impairment and restructuring charges, and acquisition-related costs | 1.1 % | 1.7 % | (0.6) % |
| Litigation and investigation costs | 1.5 % | 1.5 % | — % |
| Gains on sales, consolidation and deconsolidation of facilities | (0.8) % | (1.0) % | 0.2 % |
| Operating income | 6.2 % | 5.7 % | 0.5 % |

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) our Ambulatory Care segment, (4) services provided by our Conifer subsidiary to third parties and (5) our health plans. Revenues from our general hospitals represented approximately 78% and 83% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2016 and 2015, respectively.

Net operating revenues from our other operations were $4.582 billion and $3.370 billion in the years ended December 31, 2016 and 2015, respectively. The increase in net operating revenues from other operations during 2016 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our USPI joint venture and Aspen operations, our health plans and physician practices. Equity in earnings of unconsolidated affiliates were $131 million and $99 million for the years ended December 31, 2016 and 2015, respectively. The increase in equity in earnings of unconsolidated affiliates in the 2016 period compared to the 2015 period primarily related to our USPI joint venture.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 67 hospitals and six health plans operated throughout the years ended December 31, 2016 and 2015. The results of the following facilities are excluded from our same-hospital information: (i) Hi-Desert Medical Center, which we began operating on July 15, 2015, (ii) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (iii) SLUH, which we divested on August 31, 2015, (iv) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (v) DMC Surgery Hospital, which we closed in October 2015, (vi) our two North Carolina hospitals, which we divested effective January 1, 2016, (vii) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (viii) our

five Georgia hospitals, which we divested effective April 1, 2016.

Table of Contents

| | Years Ended December 31, | | Increase |
|---|---|---|---|
| Selected Operating Expenses | 2016 | 2015 | (Decrease) |
| Hospital Operations and other — Same-Hospital | | | |
| Salaries, wages and benefits | $ 7,121 | $ 6,965 | 2.2 % |
| Supplies | 2,484 | 2,408 | 3.2 % |
| Other operating expenses | 3,829 | 3,466 | 10.5 % |
| Total | $ 13,434 | $ 12,839 | 4.6 % |
| Ambulatory Care | | | |
| Salaries, wages and benefits | $ 594 | $ 301 | 97.3 % |
| Supplies | 365 | 188 | 94.1 % |
| Other operating expenses | 346 | 196 | 76.5 % |
| Total | $ 1,305 | $ 685 | 90.5 % |
| Conifer | | | |
| Salaries, wages and benefits | $ 959 | $ 852 | 12.6 % |
| Other operating expenses | 335 | 296 | 13.2 % |
| Total | $ 1,294 | $ 1,148 | 12.7 % |
| Rent/lease expense(1) | | | |
| Hospital Operations and other | $ 201 | $ 191 | 5.2 % |
| Ambulatory Care | 74 | 41 | 80.5 % |
| Conifer | 18 | 16 | 12.5 % |
| Total | $ 293 | $ 248 | 18.1 % |

(1) Included in other operating expenses.

Results of Operations by Segment

Our operations are reported under three segments:

· Hospital Operations and other, which is comprised of our acute care hospitals, ancillary outpatient facilities, urgent care centers, microhospitals, physician practices and health plans (certain of which are classified as held for sale as described in Note 4 to our Consolidated Financial Statements);

· Ambulatory Care, which is comprised of our USPI joint venture’s ambulatory surgery centers, urgent care centers, imaging centers and short-stay surgical hospitals, as well as Aspen’s hospitals and clinics; and

· Conifer, which provides healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions to healthcare systems and other entities.

Hospital Operations and other Segment

The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of our same 67 hospitals and six health plans operated throughout the years ended December 31, 2016 and 2015. The results of the following facilities are excluded from our same-hospital information: (i) Hi Desert Medical Center, which we began operating on July 15, 2015, (ii) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (iii) SLUH, which we divested on August 31, 2015, (iv) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (v) DMC Surgery Hospital, which we closed in October 2015, (vi) our two North Carolina hospitals, which we divested effective January 1, 2016, (vii) our four North Texas hospitals in which we divested a controlling interest effective January 1, 2016, but continue to operate, and (viii) our five Georgia hospitals, which we divested effective April 1, 2016.

Table of Contents

| | Same-Hospital Continuing Operations Years Ended December 31, | | Increase |
|---|---|---|---|
| Admissions, Patient Days and Surgeries | 2016 | 2015 | (Decrease) |
| Number of hospitals (at end of period) | 67 | 67 | — (1) |
| Total admissions | 715,502 | 717,218 | (0.2)% |
| Adjusted patient admissions(2) | 1,239,324 | 1,228,039 | 0.9 % |
| Paying admissions (excludes charity and uninsured) | 677,361 | 680,837 | (0.5)% |
| Charity and uninsured admissions | 38,141 | 36,381 | 4.8 % |
| Admissions through emergency department | 451,785 | 452,593 | (0.2)% |
| Paying admissions as a percentage of total admissions | 94.7 % | 94.9 % | (0.2)%(1) |
| Charity and uninsured admissions as a percentage of total admissions | 5.3 % | 5.1 % | 0.2 %(1) |
| Emergency department admissions as a percentage of total admissions | 63.1 % | 63.1 % | — %(1) |
| Surgeries — inpatient | 195,641 | 196,352 | (0.4)% |
| Surgeries — outpatient | 256,301 | 254,932 | 0.5 % |
| Total surgeries | 451,942 | 451,284 | 0.1 % |
| Patient days — total | 3,269,558 | 3,286,026 | (0.5)% |
| Adjusted patient days(2) | 5,612,240 | 5,567,041 | 0.8 % |
| Average length of stay (days) | 4.57 | 4.58 | (0.2)% |
| Licensed beds (at end of period) | 18,118 | 18,130 | (0.1)% |
| Average licensed beds | 18,127 | 18,217 | (0.5)% |
| Utilization of licensed beds(3) | 49.4 % | 49.4 % | — %(1) |

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

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

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

| | Same-Hospital Continuing Operations Years Ended December 31, | | Increase |
|---|---|---|---|
| Outpatient Visits | 2016 | 2015 | (Decrease) |
| Total visits | 7,273,671 | 7,176,650 | 1.4% |
| Paying visits (excludes charity and uninsured) | 6,784,173 | 6,670,711 | 1.7% |
| Charity and uninsured visits | 489,498 | 505,939 | (3.2)% |
| Emergency department visits | 2,560,308 | 2,520,481 | 1.6% |
| Surgery visits | 256,301 | 254,932 | 0.5% |
| Paying visits as a percentage of total visits | 93.3 % | 93.0 % | 0.3%(1) |

| | | | | | | |
|---|---|---|---|---|---|---|
| Charity and uninsured visits as a percentage of total visits | 6.7 | % | 7.0 | % | (0.3)% | (1) |

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

| | Same-Hospital Continuing Operations Years Ended December 31, | | |
|---|---|---|---|
| Revenues | 2016 | 2015 | Increase (Decrease) |
| Net operating revenues | $ 14,877 | $ 14,148 | 5.2 % |
| Revenues from charity and the uninsured | $ 950 | $ 879 | 8.1 % |
| Net inpatient revenues(1) | $ 9,776 | $ 9,334 | 4.7 % |
| Net outpatient revenues(1) | $ 5,347 | $ 5,103 | 4.8 % |

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $396 million and $340 million for the years ended December 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $554 million and $539 million for the years ended December 31, 2016 and 2015, respectively.

Table of Contents

| Revenues on a Per Admission, Per Patient Day and Per Visit Basis | Same-Hospital Continuing Operations Years Ended December 31, 2016 | 2015 | Increase (Decrease) |
|---|---|---|---|
| Net inpatient revenue per admission | $ 13,663 | $ 13,014 | 5.0 % |
| Net inpatient revenue per patient day | $ 2,990 | $ 2,841 | 5.2 % |
| Net outpatient revenue per visit | $ 735 | $ 711 | 3.4 % |
| Net patient revenue per adjusted patient admission(1) | $ 12,203 | $ 11,756 | 3.8 % |
| Net patient revenue per adjusted patient day(1) | $ 2,695 | $ 2,593 | 3.9 % |

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

| Provision for Doubtful Accounts | Same-Hospital Continuing Operations Years Ended December 31, 2016 | 2015 | Increase (Decrease) |
|---|---|---|---|
| Provision for doubtful accounts | $ 1,306 | $ 1,203 | 8.6 % |
| Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts | 8.1 % | 7.8 % | 0.3 %(1) |

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

| Selected Operating Expenses | Same-Hospital Continuing Operations Years Ended December 31, 2016 | 2015 | Increase (Decrease) |
|---|---|---|---|
| Hospital Operations and other | | | |
| Salaries, wages and benefits as a percentage of net operating revenues | 47.9% | 49.2 % | (1.3)%(1) |
| Supplies as a percentage of net operating revenues | 16.7% | 17.0 % | (0.3)%(1) |
| Other operating expenses as a percentage of net operating revenues | 25.7% | 24.5 % | 1.2 %(1) |

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

REVENUES

Same-hospital net operating revenues increased $729 million, or 5.2%, during the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase in same-hospital net operating revenues in the 2016 period is primarily due to volume growth in higher acuity inpatient services, higher outpatient volumes, improved terms of our managed care contracts, incremental net revenues from the California provider fee program of $44 million and an increase in our other operations revenues. Same-hospital net inpatient revenues increased $442 million, or 4.7%, while same-hospital admissions decreased 0.2% in the 2016 period compared to the 2015 period. Same-hospital net inpatient revenue per admission increased 5.0%, primarily due to the improved terms of our managed care contracts and volume growth in higher acuity service lines, in the year ended December 31, 2016. Same-hospital net outpatient revenues increased $244 million, or 4.8%, and same-hospital outpatient visits increased 1.4% in the year ended December 31, 2016 compared to the year ended December 31, 2015. Growth in outpatient revenues and volumes was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program. Same-hospital net outpatient revenue per visit increased 3.4% primarily due to the improved terms of our managed care contracts.

PROVISION FOR DOUBTFUL ACCOUNTS

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.1% and 7.8% for the years ended December 31, 2016 and 2015, respectively. The increases in the 2016 periods compared to the 2015 periods were driven by increases in uninsured revenues and volumes, and higher

Table of Contents

patient co–pays and deductibles. The table below shows the net accounts receivable and allowance for doubtful accounts by payer at December 31, 2016 and December 31, 2015:

| | December 31, 2016 | | | December 31, 2015 | | |
|---|---|---|---|---|---|---|
| | 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 | $ 404 | $ — | $ 404 | $ 360 | $ — | $ 360 |
| Medicaid | 46 | — | 46 | 70 | — | 70 |
| Net cost report settlements payable and valuation allowances | (14) | — | (14) | (42) | — | (42) |
| Managed care | 1,965 | 175 | 1,790 | 1,715 | 126 | 1,589 |
| Self-pay uninsured | 488 | 442 | 46 | 509 | 436 | 73 |
| Self-pay balance after insurance | 211 | 155 | 56 | 208 | 142 | 66 |
| Estimated future recoveries | 141 | — | 141 | 144 | — | 144 |
| Other payers | 458 | 216 | 242 | 442 | 166 | 276 |
| Total Hospital Operations and other | 3,699 | 988 | 2,711 | 3,406 | 870 | 2,536 |
| Ambulatory Care | 227 | 43 | 184 | 182 | 17 | 165 |
| Total discontinued operations | 2 | — | 2 | 3 | — | 3 |
| | $ 3,928 | $ 1,031 | $ 2,897 | $ 3,591 | $ 887 | $ 2,704 |

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, 2016, our Hospital Operations and other segment collection rate on self-pay accounts was approximately 26.1%. Our self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at December 31, 2016, 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 $9 million.

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated Hospital Operations and other segment collection rate from managed care payers was approximately 97.8% at December 31, 2016.

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 the continuing operations of our Hospital Operations and other segment of $2.725 billion and $2.578 billion at December 31, 2016 and 2015, respectively, excluding cost report settlements payable and valuation allowances of $14 million and $42 million at December 31, 2016 and 2015, respectively:

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

Table of Contents

| | December 31, 2015 | | | | |
|---|---|---|---|---|---|
| | Medicare | Medicaid | Managed Care | Indemnity, Self-Pay and Other | Total |
| 0-60 days | 90 % | 65 % | 64 % | 27 % | 62 % |
| 61-120 days | 6 % | 16 % | 16 % | 19 % | 15 % |
| 121-180 days | 2 % | 6 % | 7 % | 11 % | 7 % |
| Over 180 days | 2 % | 13 % | 13 % | 43 % | 16 % |
| Total | 100% | 100 % | 100 % | 100 % | 100% |

As of December 31, 2016, we had a cumulative total of patient account assignments to our Conifer subsidiary of approximately $2.9 billion related to our continuing operations. 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. Based on recent trends, approximately 95% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at December 31, 2016 and December 31, 2015 by aging category for the hospitals currently in the program:

| | December 31, 2016 | December 31, 2015 |
|---|---|---|
| 0-60 days | $ 84 | $ 86 |
| 61-120 days | 13 | 14 |
| 121-180 days | 4 | 7 |
| Over 180 days | 4 | 18 |
| Total | $ 105 | $ 125 |

SALARIES, WAGES AND BENEFITS

Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased by 130 basis points to 47.9% in the year ended December 31, 2016 compared to the same period in 2015. While same-hospital net operating revenues increased 5.2% in the year ended December 31, 2016 compared to the year ended December 31, 2015,

same-hospital salaries, wages and benefits increased by only 2.2% in the year ended December 31, 2016 compared to the 2015 period. The increase in same-hospital salaries, wages and benefits was primarily due to annual merit increases for certain of our employees and increased employee health benefits costs, partially offset lower annual incentive compensation expense. Salaries, wages and benefits expense for the years ended December 31, 2016 and 2015 included stock-based compensation expense of $58 million and $77 million, respectively.

At December 31, 2016, approximately 23% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 34 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have six expired contracts covering approximately 8% of our unionized employees and are negotiating renewals under extension agreements. We are also negotiating first contracts at three hospitals and one physician practice covering approximately 5% of our unionized employees where employees recently 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. Organizing activities by labor unions could increase our level of union representation in future periods.

Table of Contents

SUPPLIES

Same-hospital supplies expense as a percentage of net operating revenues decreased by 30 basis points to 16.7% in the year ended December 31, 2016 compared to the same period in 2015.

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

OTHER OPERATING EXPENSES, NET

Same-hospital other operating expenses as a percentage of net operating revenues increased by 120 basis points to 25.7% in the year ended December 31, 2016 compared 24.5% to the same period in 2015. The increase in other operating expenses was primarily due to:

- increased costs associated with funding indigent care services by hospitals we operated throughout both periods of $16 million, which costs were substantially offset by additional net patient revenues;

- increased costs of $126 million associated with our health plans due to an increase in covered lives, which costs were partially offset by increased health plan revenues; and

- increased costs of contracted services of $160 million.

Same-hospital malpractice expense in the 2016 period included a favorable adjustment of approximately $4 million due to a 16 basis point increase in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to a favorable adjustment of approximately $3 million as a result of a 12 basis point increase in the interest rate in the 2015 period.

Ambulatory Care Segment

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI into our new USPI joint venture, and we acquired Aspen, which operates nine private short-stay surgical hospitals and clinics in the United Kingdom, thereby forming our Ambulatory Care separate reportable business segment. The results of our USPI joint venture and Aspen are included in the financial and statistical information provided only for the period from acquisition to December 31, 2016.

Our USPI joint venture operates its surgical facilities in partnership with local physicians and, in many of these facilities, a healthcare system partner. We hold an ownership interest in each facility, with each being operated through a separate legal entity. The joint venture operates facilities on a day-to-day basis through management services contracts. Our sources of earnings from each facility consist of:

- management services revenues, computed as a percentage of each facility's net revenues (often net of bad debt expense); and

- our share of each facility's net income (loss), which is computed by multiplying the facility's net income (loss) times the percentage of each facility's equity interests owned by our USPI joint venture.

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. In many of the facilities our Ambulatory Care segment operates (108 of 323 facilities at December 31, 2016), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method. We control 215 of the facilities our Ambulatory Care segment operates, and we account for these investments as consolidated subsidiaries.

Table of Contents

Our net earnings from a facility are the same under either method, but the classification of those earnings differs. For consolidated subsidiaries, our financial statements reflect 100% of the revenues and expenses of the subsidiaries, after the elimination of intercompany amounts. The net profit attributable to owners other than us is classified within "net income attributable to noncontrolling interests."

For unconsolidated affiliates, our consolidated statements of operations reflect our earnings in two line items:

- equity in earnings of unconsolidated affiliates—our share of the net income of each facility, which is based on the facility's net income and the percentage of the facility's outstanding equity interests owned by us; and

- management and administrative services revenues, which is included in our net operating revenues—income we earn in exchange for managing the day-to-day operations of each facility, usually quantified as a percentage of each facility's net revenues less bad debt expense.

Our Ambulatory Care operating income is driven by the performance of all facilities our USPI joint venture operates and by the joint venture's ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 67% of those facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

The following table summarizes certain consolidated statements of operations items for the periods indicated:

| | Years Ended December 31, | |
|---|---|---|
| Ambulatory Care Results of Operations | 2016 | 2015 |
| Net operating revenues | $ 1,797 | $ 959 |
| Equity in earnings of unconsolidated affiliates | $ 122 | $ 83 |
| Salaries, wages and benefits | $ 594 | $ 301 |
| Supplies | $ 365 | $ 188 |
| Other operating expenses, net | $ 346 | $ 196 |

Our Ambulatory Care net operating revenues increased by $838 million, or 87.4%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The growth in revenues was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the

period from June 15, 2015 to December 31, 2015.

Salaries, wages and benefits expense increased by $293 million, or 97.3%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Supplies expense increased by $177 million, or 94.1%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Other operating expenses increased by $150 million 76.5%, for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increases was primarily due to our majority ownership interest in our USPI joint venture for the entire year ended December 2016 compared to only the period from June 15, 2015 to December 31, 2015.

Table of Contents

Facility Growth

The following table summarizes the changes in our same-facility revenue year-over-year on a pro forma systemwide basis, which includes both consolidated and unconsolidated (equity method) facilities. While we do not record the revenues of unconsolidated facilities, we believe this information is important in understanding the financial performance of our Ambulatory Care segment because these revenues are the basis for calculating our management services revenues and, together with the expenses of our unconsolidated facilities, are the basis for our equity in earnings of unconsolidated affiliates.

| Ambulatory Care Facility Growth | Year Ended December 31, 2016 |
|---|---|
| Net revenues | 9.6 % |
| Cases | 5.2 % |
| Net revenue per case | 4.2 % |

Joint Ventures with Healthcare System Partners

Our USPI joint venture's business model is to jointly own its facilities with local physicians and not-for-profit healthcare systems. Accordingly, as of December 31, 2016, the majority of facilities in our Ambulatory Care segment are operated in this model.

| Ambulatory Care Facilities with Healthcare System Partners | Year Ended December 31, 2016 |
|---|---|
| Facilities: | |
| With a healthcare system partner | 177 |
| Without a healthcare system partner | 146 |
| Total facilities operated | 323 |
| Change from December 31, 2015 | |
| Acquisitions | 5 |
| De novo | 4 |
| Dispositions/Mergers | (17) |
| Total decrease in number of facilities operated | (8) |

Conifer Segment

Our Conifer subsidiary generated net operating revenues of approximately $1.6 billion and $1.4 billion during the years ended December 31, 2016 and 2015, respectively, a portion of which was eliminated in consolidation as described in Note 20 to the Consolidated Financial Statements. The increase in the revenue from third-party customers, which is not eliminated in consolidation, is primarily due to new clients.

Salaries, wages and benefits expense for Conifer increased $107 million, or 12.6%, in the year ended December 31, 2016 compared to the year ended December 31, 2015 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to new clients. Conifer typically incurs start-up and other transition costs during the initial term of new client contracts.

Other operating expenses for Conifer increased $39 million, or 13.2%, in the year ended December 31, 2016 compared to the year ended December 31, 2015 due to the growth in Conifer's business primarily attributable to new clients. Conifer typically incurs start-up and other transition costs during the initial term of new client contracts.

Conifer continues to implement 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 intended to reduce denials, improve service levels to patients and increase 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.

Table of Contents

Conifer's master service agreement with Tenet expires in December 2018. Prior to the expiration, we will undertake a new fair market value analysis with respect to the pricing of these services and use that analysis in our negotiation of renewal contracts. As a result, it is possible that the pricing under the renegotiated agreements may be different from the current agreements. Any changes in the price or other terms of the contract could have a material impact on our Conifer segment's results of operations. Conifer's contract with Tenet represented approximately 41% of the net operating revenues Conifer recognized in the year ended December 31, 2016.

Consolidated

IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the year ended December 31, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $202 million. This amount included impairment charges of approximately $54 million for the write-down of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at four of our hospitals. Material adverse trends in our most recent estimates of future undiscounted cash flows of the hospitals indicated the carrying value of the hospitals' long-lived assets was not recoverable from the estimated future cash flows. We believe the most significant factors contributing to the adverse financial trends include reductions in volumes of insured patients, shifts in payer mix from commercial to governmental payers combined with reductions in reimbursement rates from governmental payers, and high levels of uninsured patients. As a result, we updated the estimate of the fair value of the hospitals' long-lived assets and compared the fair value estimate to the carrying value of the hospitals' long-lived assets. Because the fair value estimates were lower than the carrying value of the long-lived assets, an impairment charge was recorded for the difference in the amounts. Unless the anticipated future financial trends of these hospitals improve to the extent that the estimated future undiscounted cash flows exceed the carrying value of the long-lived assets, these hospitals are at risk of future impairments, particularly if we spend significant amounts of capital at the hospitals without generating a corresponding increase in the hospitals' fair value or if the fair value of the hospitals' real estate or equipment declines. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $163 million as of December 31, 2016 after recording the impairment charges. We also recorded $19 million of impairment charges related to investments and $14 million related to other intangible assets, primarily contract related intangibles and capitalized software costs not associated with the hospitals described above. Of the total impairment charges recognized for the year ended December 31, 2016, $76 million related to our Hospital Operations and other segment, $8 million related to our Ambulatory Care segment, and $3 million related to our Conifer segment. We also recorded $35 million of employee severance costs, $14 million of restructuring costs, $14 million of contract and lease termination fees, and $52 million in acquisition-related costs, which include $20 million of transaction costs and $32 million of acquisition integration costs.

During the year ended December 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $318 million, including $168 million of impairment charges. We recorded an impairment charge of approximately $147 million to write-down assets held for sale to their estimated fair value, less estimated costs to sell, as a result of entering into a definitive agreement for the sale of SLUH during the three months ended June 30, 2015, as further described in Note 5. We also recorded impairment charges of approximately $19 million for the write-down

of buildings, equipment and other long-lived assets, primarily capitalized software cost classified as other intangible assets, to their estimated fair values at two of our hospitals. The aggregate carrying value of assets held and used of the hospitals for which impairment charges were recorded was $45 million as of December 31, 2015 after recording the impairment charge. We also recorded $2 million of impairment charges related to investments. We also recorded $25 million of employee severance costs, $6 million of restructuring costs, $19 million of contract and lease termination fees, and $100 million in acquisition-related costs, which include $55 million of transaction costs and $45 million of acquisition integration costs.

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

Table of Contents

LITIGATION AND INVESTIGATION COSTS

Litigation and investigation costs for the years ended December 31, 2016 and 2015 were $293 million and $291 million, respectively. Of these amounts, $278 million and $219 million for the years ended December 31, 2016 and 2015, respectively, were attributable to accruals for the Clinica de la Mama matter, which is further described in Note 14 to our Consolidated Financial Statements.

GAINS ON SALES, CONSOLIDATION AND DECONSOLIDATION OF FACILITIES

During the year ended December 31, 2016, we recorded gains on sales, consolidation and deconsolidation of facilities of approximately $151 million, primarily comprised of a $113 million gain from the sale of our Atlanta-area facilities and $33 million of gains related to the consolidation of certain businesses of our USPI joint venture due to ownership changes.

During the year ended December 31, 2015, we recorded gains on sales, consolidation and deconsolidation of facilities of approximately $186 million, comprised of a $151 million gain on deconsolidation due to our joint venture with Baylor Scott & White Health (“BSW”), a $3 million gain from the sale of our North Carolina facilities and $32 million of gains related to the consolidation and deconsolidation of certain businesses of our USPI joint venture due to ownership changes.

INTEREST EXPENSE

Interest expense for the year ended December 31, 2016 was $979 million compared to $912 million for the year ended December 31, 2015, primarily due to increased borrowings related to our 2015 acquisitions.

INCOME TAX EXPENSE

During the year ended December 31, 2016, we recorded income tax expense of $67 million in continuing operations on pre-tax income of $248 million, compared to income tax expense of $68 million on pre-tax income of $144 million during the year ended December 31, 2015. The reconciliation between the amount of recorded income tax expense (benefit) and the amount calculated at the statutory federal tax rate is shown below.

| | Years Ended December 31, | |
|---|---|---|
| | 2016 | 2015 |
| Tax expense at statutory federal rate of 35% | $ 87 | $ 50 |
| State income taxes, net of federal income tax benefit | 16 | 18 |
| Expired state net operating losses, net of federal income tax benefit | 35 | 11 |
| Tax attributable to noncontrolling interests | (106) | (59) |
| Nondeductible goodwill | 29 | 22 |
| Nontaxable gains | (11) | (11) |
| Nondeductible litigation costs | 37 | 44 |
| Nondeductible acquisition costs | 1 | 4 |
| Nondeductible health insurance provider fee | 2 | 2 |
| Changes in valuation allowance | (25) | 4 |
| Change in tax contingency reserves, including interest | (9) | 7 |
| Amendment of prior-year tax returns | — | (17) |
| Prior-year provision to return adjustments and other changes in deferred taxes | 12 | (12) |
| Other items | (1) | 5 |
| | $ 67 | $ 68 |

NET INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS

Net income attributable to noncontrolling interests was $368 million for the year ended December 31, 2016 compared to $218 million for the year ended December 31, 2015. Net income attributable to noncontrolling interests for

Table of Contents

the year ended December 31, 2016 was comprised of $31 million related to our Hospital Operations and other segment, $285 million related to our Ambulatory Care segment and $52 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $65 million was related to the minority interest in our USPI joint venture.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

The financial information provided throughout this report, including our Consolidated Financial Statements and the notes thereto, has been prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). However, we use certain non-GAAP financial measures defined below in communications with investors, analysts, rating agencies, banks and others to assist such parties in understanding the impact of various items on our financial statements, some of which are recurring or involve cash payments. We use this information in our analysis of the performance of our business, excluding items we do not consider relevant to the performance of our continuing operations. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure defined by the Company as net income available (loss attributable) to Tenet Healthcare Corporation common shareholders before (1) the cumulative effect of changes in accounting principle, (2) net loss (income) attributable to noncontrolling interests, (3) income (loss) from discontinued operations, (4) income tax benefit (expense), (5) investment earnings (losses), (6) gain (loss) from early extinguishment of debt, (7) interest expense, (8) litigation and investigation (costs) benefit, net of insurance recoveries, (9) net gains (losses) on sales, consolidation and deconsolidation of facilities, (10) impairment and restructuring charges and acquisition-related costs, and (11) depreciation and amortization. Litigation and investigation costs do not include ordinary course of business malpractice and other litigation and related expense.

The Company believes the foregoing non-GAAP measure is useful to investors and analysts because it presents additional information on the Company's financial performance. Investors, analysts, Company management and the Company's Board of Directors utilize this non-GAAP measure, in addition to GAAP measures, to track the Company's financial and operating performance and compare the Company's performance to its peer companies, which utilize similar non-GAAP measures in their presentations. The Human Resources Committee of the Company's Board of Directors also uses certain of these measures to evaluate management's performance for the purpose of determining incentive compensation. Additional information regarding the purpose and utility of specific non-GAAP measures used by the Company is set forth below. The Company believes that Adjusted EBITDA is a useful measure, in part, because certain investors and analysts use both historical and projected Adjusted EBITDA, in addition to other GAAP and non-GAAP measures, as factors in determining the estimated fair value of shares of the Company's common stock. Company management also regularly reviews the Adjusted EBITDA performance for each operating segment. The Company does not use Adjusted EBITDA to measure liquidity, but instead to measure operating performance. This non-GAAP measure may not be comparable to similarly titled measures reported by other companies. Because this measure excludes many items that are included in our financial statements, it does not provide a complete measure of our operating performance. Accordingly, investors are encouraged to use GAAP measures when evaluating the Company's financial performance.

75

Table of Contents

The table below shows the reconciliation of Adjusted EBITDA to net income available (loss attributable) to Tenet Healthcare Corporation common shareholders (the most comparable GAAP term) for the years ended December 31, 2016 and 2015:

| | Years Ended December 31, | |
|---|---|---|
| | 2016 | 2015 |
| Net loss attributable to Tenet Healthcare Corporation common shareholders | $ (192) | $ (140) |
| Less: Net income attributable to noncontrolling interests | (368) | (218) |
| Net income (loss) from discontinued operations, net of tax | (5) | 2 |
| Net income from continuing operations | 181 | 76 |
| Income tax expense | (67) | (68) |
| Investment earnings (losses) | 8 | 1 |
| Loss from early extinguishment of debt | — | (1) |
| Interest expense | (979) | (912) |
| Operating income | 1,219 | 1,056 |
| Litigation and investigation costs | (293) | (291) |
| Gains on sales, consolidation and deconsolidation of facilities | 151 | 186 |
| Impairment and restructuring charges, and acquisition-related costs | (202) | (318) |
| Depreciation and amortization | (850) | (797) |
| Adjusted EBITDA | $ 2,413 | $ 2,276 |
| | | |
| Net operating revenues | $ 19,621 | $ 18,634 |
| | | |
| Net loss from continuing operations as a % of operating revenues | (1.0) % | (0.8) % |
| | | |
| Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin) | 12.3 % | 12.2 % |

Table of Contents

RESULTS OF OPERATIONS FOR THE YEAR ENDED DECEMBER 31, 2015 COMPARED TO THE YEAR ENDED DECEMBER 31, 2014

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, 2015 and 2014:

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2015 | 2014 | Increase (Decrease) |
| Net operating revenues: | | | |
| General hospitals | $ 16,741 | $ 15,518 | $ 1,223 |
| Other operations | 3,370 | 2,390 | 980 |
| Net operating revenues before provision for doubtful accounts | 20,111 | 17,908 | 2,203 |
| Less provision for doubtful accounts | 1,477 | 1,305 | 172 |
| Net operating revenues | 18,634 | 16,603 | 2,031 |
| Equity in earnings of unconsolidated affiliates | 99 | 12 | 87 |
| Operating expenses: | | | |
| Salaries, wages and benefits | 9,011 | 8,023 | 988 |
| Supplies | 2,963 | 2,630 | 333 |
| Other operating expenses, net | 4,555 | 4,114 | 441 |
| Electronic health record incentives | (72) | (104) | 32 |
| Depreciation and amortization | 797 | 849 | (52) |
| Impairment and restructuring charges, and acquisition-related costs | 318 | 153 | 165 |
| Litigation and investigation costs | 291 | 25 | 266 |
| Gains on sales, consolidation and deconsolidation of facilities | (186) | — | (186) |
| Operating income | $ 1,056 | $ 925 | $ 131 |

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2015 | 2014 | Increase (Decrease) |
| Net operating revenues | 100.0% | 100.0% | — % |
| Equity in earnings of unconsolidated affiliates | 0.5 % | 0.1 % | 0.4 % |
| Operating expenses: | | | |
| Salaries, wages and benefits | 48.4 % | 48.3 % | 0.1 % |
| Supplies | 15.9 % | 15.8 % | 0.1 % |
| Other operating expenses, net | 24.4 % | 24.8 % | (0.4) % |
| Electronic health record incentives | (0.4) % | (0.6) % | 0.2 % |
| Depreciation and amortization | 4.3 % | 5.1 % | (0.8) % |

| | | | | | | |
|---|---|---|---|---|---|---|
| Impairment and restructuring charges, and acquisition-related costs | 1.7 | % | 0.9 | % | 0.8 | % |
| Litigation and investigation costs | 1.5 | % | 0.2 | % | 1.3 | % |
| Gains on sales, consolidation and deconsolidation of facilities | (1.0) | % | — | % | (1.0) | % |
| Operating income | 5.7 | % | 5.6 | % | 0.1 | % |

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) our Ambulatory Care segment, (4) services provided by our Conifer subsidiary to third parties and (5) our health plans. Revenues from our general hospitals represented approximately 83% and 87% of our total net operating revenues before provision for doubtful accounts for the years ended December 31, 2015 and 2014, respectively.

Table of Contents

Net operating revenues from our other operations were $3.370 billion and $2.390 billion in the years ended December 31, 2015 and 2014, respectively. The increase in net operating revenues from other operations during 2015 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our USPI joint venture and Aspen acquisition, our health plans and physician practices. Equity in earnings of unconsolidated affiliates were $99 million and $12 million for the years ended December 31, 2015 and 2014, respectively. The increase in equity in earnings of unconsolidated affiliates in the 2015 period compared to the 2014 period primarily relates to our USPI joint venture.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 75 hospitals and six health plans operated throughout the years ended December 31, 2015 and 2014. 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, Emanuel Medical Center, which we acquired on August 1, 2014, Hi-Desert Medical Center, which we began operating on July 15, 2015, our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, SLUH, which we sold on August 31, 2015, our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and DMC Surgery Hospital, which we closed in October 2015, are excluded. Certain previously reported information has been reclassified to conform to the current-year presentation, primarily related to the sale of SLUH and our contribution of freestanding ambulatory surgery and imaging center assets to the USPI joint venture. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

| | Same Hospital Continuing Operations Years Ended December 31, | | | |
|---|---|---|---|---|
| Selected Operating Expenses | 2015 | 2014 | Increase (Decrease) | |
| Hospital Operations and other — Same-Hospital | | | | |
| Salaries, wages and benefits | $ 7,438 | $ 7,005 | 6.2 | % |
| Supplies | 2,590 | 2,459 | 5.3 | % |
| Other operating expenses | 3,779 | 3,569 | 5.9 | % |
| Total | $ 13,807 | $ 13,033 | 5.9 | % |
| Salaries, wages and benefits per adjusted patient admission(1) | $ 5,579 | $ 5,433 | 2.7 | % |
| Supplies per adjusted patient admission(1) | 1,943 | 1,889 | 2.9 | % |
| Other operating expenses per adjusted patient admission(1) | 2,856 | 2,774 | 3.0 | % |
| Total per adjusted patient admission | $ 10,378 | $ 10,096 | 2.8 | % |
| Ambulatory Care | | | | |
| Salaries, wages and benefits | $ 301 | $ 87 | 246.0 | % |
| Supplies | 188 | 61 | 208.2 | % |
| Other operating expenses | 196 | 74 | 164.9 | % |
| Total | $ 685 | $ 222 | 208.6 | % |
| Conifer | | | | |
| Salaries, wages and benefits | $ 852 | $ 727 | 17.2 | % |
| Other operating expenses | 296 | 263 | 12.5 | % |
| Total | $ 1,148 | $ 990 | 16.0 | % |

| | | | | |
|---|---|---|---|---|
| Rent/lease expense(2) | | | | |
| Hospital Operations and other | $ 214 | $ 191 | 12.0 | % |
| Conifer | 16 | 21 | (23.8) | % |
| Ambulatory Care | 41 | 22 | 86.4 | % |
| Total | $ 271 | $ 234 | 15.8 | % |

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

(2) Included in other operating expenses.

Table of Contents

Results of Operations by Segment

Our operations are reported under three segments: Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, urgent care facilities, freestanding emergency departments, physician practices and health plans; Ambulatory Care, which is comprised of our freestanding ambulatory surgery and imaging centers, short-stay surgical facilities and Aspen's hospitals and clinics; and Conifer, which operates revenue cycle management and patient communication and engagement services businesses.

Hospital Operations and other Segment

The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of our same 75 hospitals and six health plans operated throughout the years ended December 31, 2015 and 2014. 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, Emanuel Medical Center, which we acquired on August 1, 2014, Hi-Desert Medical Center, which we began operating on July 15, 2015, our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, SLUH, which we sold on August 31, 2015, our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, and DMC Surgery Hospital, which we closed in October 2015, are excluded. Certain previously reported information has been reclassified to conform to the current-year presentation, primarily related to the sale of SLUH and our contribution of freestanding ambulatory surgery and imaging center assets to the USPI joint venture. These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

| | Same-Hospital Continuing Operations Years Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| Admissions, Patient Days and Surgeries | 2015 | | 2014 | | Increase (Decrease) | |
| Total admissions | 774,480 | | 765,951 | | 1.1 | % |
| Adjusted patient admissions(1) | 1,333,227 | | 1,301,936 | | 2.4 | % |
| Paying admissions (excludes charity and uninsured) | 733,155 | | 722,455 | | 1.5 | % |
| Charity and uninsured admissions | 41,325 | | 43,496 | | (5.0) | % |
| Admissions through emergency department | 489,401 | | 479,805 | | 2.0 | % |
| Paying admissions as a percentage of total admissions | 94.7 | % | 94.3 | % | 0.4 | %(2) |
| Charity and uninsured admissions as a percentage of total admissions | 5.3 | % | 5.7 | % | (0.4) | %(2) |
| Emergency department admissions as a percentage of total admissions | 63.2 | % | 62.6 | % | 0.6 | %(2) |
| Surgeries — inpatient | 211,063 | | 209,385 | | 0.8 | % |
| Surgeries — outpatient | 276,890 | | 273,248 | | 1.3 | % |
| Total surgeries | 487,953 | | 482,633 | | 1.1 | % |

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient days — total | 3,573,155 | | 3,566,694 | | 0.2 | % |
| Adjusted patient days(1) | 6,083,749 | | 5,993,861 | | 1.5 | % |
| Average length of stay (days) | 4.61 | | 4.66 | | (1.1) | % |
| Number of hospitals (at end of period) | 75 | | 75 | | — | (2) |
| Licensed beds (at end of period) | 19,882 | | 19,984 | | (0.5) | % |
| Average licensed beds | 19,969 | | 19,905 | | 0.3 | % |
| Utilization of licensed beds(3) | 49.0 | % | 49.1 | % | (0.1) | %(2) |

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

(2) The change is the difference between 2015 and 2014 amounts shown.

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

Table of Contents

| | Same-Hospital Continuing Operations Years Ended December 31, | | | | Increase (Decrease) | |
|---|---|---|---|---|---|---|
| Outpatient Visits | 2015 | | 2014 | | | |
| Total visits | 7,831,785 | | 7,496,243 | | 4.5 | % |
| Paying visits (excludes charity and uninsured) | 7,213,214 | | 6,859,531 | | 5.2 | % |
| Charity and uninsured visits | 618,571 | | 636,712 | | (2.8) | % |
| Emergency department visits | 2,816,943 | | 2,738,233 | | 2.9 | % |
| Surgery visits | 276,890 | | 273,248 | | 1.3 | % |
| Paying visits as a percentage of total visits | 92.1 | % | 91.5 | % | 0.6 | %(1) |
| Charity and uninsured visits as a percentage of total visits | 7.9 | % | 8.5 | % | (0.6) | %(1) |

(1) The change is the difference between 2015 and 2014 amounts shown.

| | Same-Hospital Continuing Operations Years Ended December 31, | | Increase (Decrease) | |
|---|---|---|---|---|
| Revenues | 2015 | 2014 | | |
| Net operating revenues | $ 15,334 | $ 14,553 | 5.4 | % |
| Revenues from charity and the uninsured | $ 992 | $ 1,025 | (3.2) | % |
| Net inpatient revenues(1) | $ 10,079 | $ 9,615 | 4.8 | % |
| Net outpatient revenues(1) | $ 5,630 | $ 5,271 | 6.8 | % |

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $374 million and $381 million for the years ended December 31, 2015 and 2014, respectively. Net outpati